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"Effectiveness of Community Mobilization Strategies on Diabetic Patient's Satisfaction with selected Governmental Health Services in Nablus Villages .Palestine "

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Dedication

I dedicate this dissertation to my late father and beloved mother .

To my darling wife; Ghada,

To my cherished daughter; Maryam,

To my precious sons; Mustafa and Mohammed .

To my well-regarded sisters and brothers.

To my best friend Abdel Salam Owaidat who gave me help and support.

To my uncle Dr Abdel Karim, and Hatem Sawlmeh, Abdel Mohsen

And to all who gave me help and supported me through my life.

Osama Ayesh

Declaration

I certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed:
Osama Ayesh

Osama Ayesh

Date: 4/3/2013

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Abstract

Patient satisfaction is an attitude of person's general orientation toward a total experience of health care. Satisfaction comprises both cognitive and emotional facets and relates to previous experiences, expectations and social networks. It is a positive evaluation of distinct dimensions of health care (Doherty, 2003).

Community mobilization is carried out in primary health care programs (including chronic illnesses) to stimulate the community to be active in demanding what they need, and actively participating in solving their own problems (USAID-Project). In Palestine, as in many developing countries, community mobilization is used and employs a number of tools namely promotional to increase people awareness in primary health care services campaigns, use of informational flyers, posters, electronic and the print media, trips and media talk shows. These tools are usually used in combination .

This cross sectional study was conducted in Nablus governmental primary health care centers from December 2011- January 2012 after community mobilization implemented by MoH in Nablus district (Huwwara and Asira) with support from USAID compared with similar governmental services in comparable communities that were not exposed by community mobilization strategies (Beta and Qabalan). The goal was to explore the effect of community mobilization strategies on diabetic patient satisfaction in selected governmental health centers in Nablus villages and to determine factors affecting patient satisfaction including; quality of services, cleanliness, waiting time, privacy, services provided, learning and communication, accessibility and community participate. Also the study was set out to recognize the appropriateness of the content of the mobilization message, the impact of community mobilization on community participation in primary health care programs, and the challenges affecting the effectiveness of community mobilization and participation.

A total of 152 adult patients selected randomly were interviewed using a structured 5-point Likert scale questionnaire to rate the level of satisfaction. The questionnaire was filled by direct face to face interview and the data were analyzed using (SPSS version 13).

Both genders were represented (males 41.4% and females 58.6%), 27% of study population was high school/Tawjihi. 42.8% was poor with a monthly income below 200JDs (about US$300). 80.3% had visited the centers more than three times, 49.3% patients had chosen the center because of the

availability of a specialist in the center while most of them have a governmental insurance (95.4%), whereas 71.7% have positive history of diabetes, 44.1% of patients have diseases like hypertension, heart and kidney diseases. While 87.5% of them have the diabetic disease since over than a year, 73.7% had the direct treatment for diabetic disease. Among domains, the quality of services had the highest overall satisfaction at 78.4%, followed by cleanliness 76%, learning and communication76%, privacy 74%, waiting time 73%, accessibility 72%, services delivered 70% and finally community participate at 46% respectively. Overall, the results revealed a relative impact of community mobilization as responses evidence an average of 71.5% satisfaction with diabetic health services provided at (Asira 78% and Huwwara 75%) that received community mobilization. Otherwise it was also noted that compared (Beta 70% and Qabalan 63%) showed lower satisfaction centers that did not receive community mobilization.

Despite this evidence of satisfaction, the study results showed that there are some leading factors of dissatisfaction attributed to a range of factors as; long waiting time to enter the examination room, some of the service provided like (foot care, lack of some specialists) and privacy tools as the doctors not closing exam room door, some of them are harder to control than others. It is highly recommended to raise the community awareness regarding the importance of their health and cleanliness. In addition, other recommendations should take place onsite as: reducing the waiting time before entering the exam room;, need for increasing training for different types of providers and staff members at the national level. The results clearly indicate the need for staff caring and cooperation, the availability of privacy, as well as the service quality. Moreover, providers have to raise awareness for the communities to participate in decision-making process and contribute to the evaluation of programs. It is recommended that this current study may be reviewed, critiqued, and even replicated using more varied samples, variables and other survey and measurement techniques to provide an opportunity for comparison of results.

" قياس فعالية استراتيجيات التعبئة المجتمعية على رضا مرضى السكري عن الخدمات المقدمة لهم في مراكز الرعاية الصحية الأولية في أربع قرى في منطقة نابلس، فلسطين"

ملخص الدراسة

هدفت هذه الدراسة إلى تحديد مدى تأثير استراتيجيات التعبئة المجتمعية على رضا مرضى السكري عن الخدمات الصحية المقدمة لهم في برامج الرعاية الصحية الأولية في منطقة نابلس، ولتحقيق هذا الهدف العام تم تحديد العوامل التي تؤثر على رضا المريض بما في ذلك نوعية الخدمات، النظافة، وقت الانتظار، الخصوصية، الخدمات المقدمة، التعلم والاتصال، إمكانية الوصول والتحصل على الخدمة و المشاركة المجتمعية.

وقد أجريت دراسة مقطعية في مراكز محافظة نابلس للرعاية الصحية الأولية الحكومية في الفترة من كانون الأول/ديسمبر ٢٠١١ إلى كانون الثاني/يناير ٢٠١٢حيث تحظى التعبئة المجتمعية التي تنفذها وزارة الصحة في محافظة نابلس بدعم من الوكالة الأمريكية للتنمية وبالمقارنة مع الخدمات الحكومية المماثلة في المجتمعات المشابهة. والتي لم تحظى باستراتيجيات تعبئة المجتمع. تم اختيار إجمالي (١٥٢) مريضا من كبار السن وذلك بأخذ عينة طبقية عشوائية وأجريت مقابلات مع استخدام إستبانة شاملة لقياس معدل مستوى رضا مرضى السكري باستخدام مقياس لكرت الخماسي. وقد وزع الاستبيان وعبئ عن طريق المقابلة وجها لوجه مباشرة واستخدم الباحث الحزمة الإحصائية الاجتماعية(SPSS) لتحليل البيانات إحصائيا.

على الصعيد الديمغرافي، فقد بينت الدراسة أن كلا الجنسين (الذكور ٤١,٤%، إناث٥٨,٦%) قد شاركوا في الدراسة واستجابوا بشكل كبير، و٢٧% من الذين شاركوا كان تحصيلهم العلمي الدراسة الثانوية /التوجيهي ، ٤٢,٨% ممن كانت نسبة دخلهم الشهري سيئة اقل من ٢٠٠ دينار أردني (حوالي ٣٠٠ دولار أمريكي)، أما بالنسبة للعوامل الأخرى فقد تبين أن ٨٠,٣% زاروا المركز أكثر من ثلاث مرات خلال الشهر، و ٤٩,٣% كان سبب اختيارهم للمركز وجود أخصائي، والأغلبية من المرضى(٩٥,٤%) يحملون تأمينا صحيا حكوميا، و٧١,٧% كان لديهم تاريخ مرضي ايجابي للسكري، وكما بينت الدراسة أيضا أن ٤٤,١% من مرضى السكري يعانون من أمراض أخرى مثل الضغط والقلب والكلى وبينما ٨٧,٥% يعانون من مرض السكري منذ أكثر من سنة و٧٣,٧% تلقوا العلاج بعد اكتشاف مرض السكري مباشرة.

أما في المجالات الثمانية المستخدمة في الدراسة فقد كانت على النحو الآتي: كانت جودة الخدمة أعلى درجات الرضا العام بنسبة 79% تليها النظافة ٧٦% والتعلم والاتصال 76%، والخصوصية 74%، ووقت الانتظار 73% وسهولة الوصول 72% والخدمات المقدمة 70% وأخيرا مشاركة المجتمع 46%.

كشفت نتائج الدراسة نسبة رضا عالية بمعدل (71.5%) للخدمات المقدمة في المراكز الحكومية في نابلس حيث كانت في (عصيرة 78%، حوارة 75%) للقرى التي تلقت تعبئة مجتمعية محلية، بينما (بيتا 70% و قبلان 63%) أظهرت نسبة رضا اقل في المراكز التي لم تتلق تعبئة مجتمعية محلية.

وعلى الرغم من هذه النسبة من الرضا، فقد أظهرت نتائج الدراسة أن هناك بعض العوامل الرئيسية لعدم الرضا يعزى إلى مجموعة من العوامل؛ هنالك فترة طويلة في انتظار الوقت لدخول غرفة الفحص، و لم تقدم بعض من الخدمات مثل (رعاية القدمين، عدم وجود بعض المتخصصين) وأدوات الخصوصية مثل عدم غلق الأطباء باب غرفة الفحص).

خلصت هذه الدراسة إلى عدة توصيات منها: ضرورة أن يتم توعية المجتمع بشدة بشأن أهمية صحتهم وبالنظافة. وبالإضافة إلى ذلك ينبغي أن تؤخذ التوصيات الأخرى بعين الاعتبار مثل: خفض فترة الانتظار قبل الدخول إلى غرفة الفحص، توفير ألخصوصية وتحسين جودة الخدمة. والحاجة إلى زيادة التدريب لجميع مقدمي الخدمات والموظفين على الصعيد الوطني. النتائج تشير بوضوح إلى الحاجة إلى رعاية الموظفين، وعلاوة على ذلك، على مقدمي الخدمة رفع مستوى الوعي بالمشاركة في عملية صنع القرار والمساهمة في تقييم البرامج. أخيرا، هذه الدراسة هي الأولى من نوعها في هذا المجال في فلسطين ويمكن أن تكون خلفية لأي دراسة لاحقة.

Table of Abbreviations

Abbreviation	Abbreviation Expansion
ACNP	**Acute Care Nurses Practitioners**
BCC	**Behavior Change Community**
BCM	**Behavior Change Modules**
CBOs	**Community Based Organizations**
CC	**Community Capacity**
CCB	**Community Capacity Building**
CM	**Community Mobilization**
CMAC	**Community Mobilization Action Cycle**
COPL	**Client–Oriented Provider**
HFA	**Health For All**
HWC	**Health Work Committee**
MoH	**Ministry of Health**
MTCT	**Mother To Child Transmission**
NCDs	**Non-Communicable Diseases**
NGOs	**Non–Governmental Organizations**
PAHO	**Pan American Health Organization**
PCBS	**Palestinian central bureau statistics**
PDM	**Participatory Decision Making**
PHC	**Primary Health Care**
PHCS	**Primary Health Care service**
PLA	**Participatory Learning and Action**
PS	**Patient satisfaction**
SWOT	**Strengths Weakness Opportunities and Threats**
UNRWA	**United Nations Relief and work Palestine Refugees Agency**
WB	**West Bank**
WHO	**World Health Organization**

Chapter One: Background and Significance

1.1 Introduction

Historically, health interventions in the West Bank and Gaza Strip have utilized different models of community mobilization (CM) that aimed to improve the health of the Palestinian population. Improving health conditions and status of the Palestinian people in the West Bank and Gaza Strip is considered by local health providers as a developmental issue that requires mobilization at all levels and sectors. Many of the inputs for improving the health of the Palestinian people lie outside the healthcare system and are very much a reflection of socio-cultural, economic, and political realities. Therefore, improving the health status of Palestinians requires improvement in the political, economic, social, and environmental conditions, and not merely the provision of medical and healthcare services (Shaheen, 2005).

Community mobilization is defined as *"a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others"* **(**Grabman and Snetro, 2003).

Community mobilization, a key strategy for increasing demand for and use of health services, is a process that helps communities to identify their own needs and to respond to and address these needs. Within the Palestinian health care system and USAID flagship project as an aid for Palestinian health care system, community mobilization is being implemented in selected governmental primary health care centers in north west bank (MoH, 2012).

Gaining the participation of community members can help providers raise awareness both of health issues at the community level and of social and cultural issues that may promote or inhibit use of information and services, as well as improve clients' understanding of the methods or services being offered. Specific barriers to service access and use can be addressed and service utilization increased (Aquire project, 2006).

Patient satisfaction is an attitude of person's general orientation towards a total experience of health care. Satisfaction comprises both cognitive and emotional facets and relates to previous experiences, expectations and social networks (Keegan, 2003).

It is a positive evaluation of distinct dimensions of health care, every organization nowadays is concerned with satisfying the users of its products or services, they are known as clients, customers, consumers or patients, satisfaction, like many other psychological concepts, is easy to understand but hard to define, the concept of satisfaction overlaps with similar themes such as happiness, contentment and quality of life. Satisfaction is not some pre-existing phenomenon waiting to be measured, but a judgment people form over time as they reflect on their experience and is achieved when the patient's perception of the quality of care and services that they receive in healthcare setting has been positive, satisfying and meets their expectations (Alsharif, 2008).

Chronic diseases are now the leading cause of premature mortality and disability globe in developed and developing countries, the most commonly occurring chronic diseases and those of greatest importance for public health are cardiovascular diseases, hypertension, diabetes, cancer, stroke and chronic respiratory diseases (Halpin, 2010).

In the Eastern Mediterranean Region, non-communicable diseases (NCDs) are the major cause of premature adult death, representing a major health challenge, these conditions can be prevented and controlled using available knowledge. Without national strategic action, however, deaths from NCDs are expected to increase by 17% from 2005 to 2015. There are several problems facing countries of the region in dealing with the challenges chronic illness: lack of national risk factor surveillance; lack of harmonization of monitoring and surveillance methodologies; no linking of mortality data to NCD prevention and control; lack of availability of a model of integrated care for an NCD prevention programme; and inadequate national capacity-building and lack of programme sustainability (Al-Nozha, 2004).

Based on that, community mobilization implemented by USAID on Ministry of Health selected primary health care centers have been a debate for effectiveness, therefore this study will identify effectiveness of community mobilization strategies

on diabetic patient satisfaction with selected governmental health services in Nablus villages.

1.2 Community mobilizing

It is a strategy for involving community members in the process of defining and transforming social problems. The term also refers to the process of moving a group of people from a state of inaction (or ineffective action) toward effective action, on issues of real concern to them. This action builds a sense of collective *empowerment* and *efficacy* (the expectation and belief that the community has the knowledge and ability to get the job done)(www.community change.org).

Community mobilizing can take several different forms, depending on the extent to which "grassroots" community members (neighborhood residents or local group members) versus official community and government leaders and organizations are actively involved in defining the problems and deciding on solutions. Community mobilizing efforts can involve both confrontational and consensus-seeking methods of creating change (www.community change.org).

Mobilizing is accomplished through sequential processes that involve linking: **Awareness** (of the problem and its causes, consequences, costs, etc.) to **Action** (the community taking steps to remedy the problem or prevent it from happening again) in order to bring about **Change.**

This process is expressed as: **AWARENESS + COMMUNITY ACTION = CHANGE**

Sustained mobilization takes place when communities remain active and empowered after the program ends. Communities lead or participate in all stages, from start to finish. With community mobilization, the role of the implementing agency shifts from a more traditional one of teacher/advisor/leader to that of facilitator (www.community change.org).

The effectiveness of empowerment strategies has identified two major pathways. The processes by which it is generated and its effects in improving health and reducing health disparities. Empowerment is recognized both as an outcome by itself, and as intermediate step to long–term health status and disparity outcome. Within the first pathway, arrange of outcome has been identified on multiple levels and domains; psychological, organizational and community–level and within household family,

economic, political, programs and services (such as water system, health, education) and legal spheres; there is evidence-based on multi-level research designs that empowering initiatives can lead to health outcome and that empowerment is available public health strategy (Wallerstein, 2006).

1.3 Strategies of community mobilization

1.3.1 Health communication strategies:

Health Communication is the process of promoting health by communicating health-related messages (http://www.thcu.ca, 1995). The two most common forms of health communication are education and persuasion campaigns aimed at increasing knowledge or changing health-related attitudes or behaviors. There is growing interest in health communication methods such as media advocacy, which aims to alter the social, political and environmental determinants of health.

Health communication incorporates a number of diverse activities, including interactions between service providers and clients, classes and self-help groups, worksite and school programming, mass mailings, distribution of pamphlets and booklets, telephone hotlines, mass communication campaigns (e.g., television, radio and newspapers) and community events such as contests, races and fairs (http://www.thcu.ca, 1995).

Health communication strategies can be directed towards individuals, networks or small groups such as families, organizations such as worksites and schools, and societal units ranging in size from communities to entire nations.

1.3.1.2 Ways of health communication

Channel refers to the way a health communication message is sent, in other words, the communication medium or path. There are direct channels which are interpersonal such as doctor to client, friend to friend, parent to child, and teacher to student. There are also indirect channels, these vary in terms of the size and diversity of the audience they reach from broadcast, such as television, radio and print.

Communication refers to the exchange and sharing of information, attitudes, ideas or emotions. While early definitions of communication stressed a linear movement from

a source to a receiver, current thinking stresses mutuality and shared perceptions; instead of "sending" or "receiving," people (http://www.thcu.ca, 1995).

Communication planning is a systematic and creative activity in which information, attitudes, emotions and ideas are managed to be exchanged and transmitted via specific messages through specific channels. Objectives and goals are established for communication efforts. Efforts to shape and disseminate messages in order to accomplish those goals and objectives are the elements of communication planning.

Message is that which is transmitted through the communication process. A message exists at three levels: a set of words or images expressed somewhere, somehow; the meaning of communication content as perceived or intended by the individual expressing it; and the meaning attributed to it by those receiving it.The Palestinian journalist gains important skill in health messaging, the Ministry of Health (MoH) is tackling the prevention of non communicable diseases (NCDs), activating its health education campaign through a joint-training workshop with local media outlets in Nablus; the largest city in the West Bank.

1.4 Champion community strategy

A community champion is anyone - a public official, a community leader, a concerned citizen, a health or human service worker, a volunteer - who works hard and well to start and/or support an initiative or intervention, to bring a program or idea to reality, or to otherwise improve the quality of life of a particular group or of the community as a whole. He might be a true community hero - an inspired visionary like the minister described above - or she might be the volunteer who's always there and willing to do whatever has to be done to keep things going.

Encouraging the organization to mobilize communities in health sector dialogue, demand for transparent and accountable delivery of quality of healthcare is increasing.

1.4.1 Champion community process includes the following:

1- Health status analysis for each community.

2- Community action plan is developed in each community with targets.

3- Community–clinic board establishment.

4- Implementation of contract deliverables and other activities related to action plan.

5- Assess the model for scaling (SWOT).

6- Select community champion.

1.5 Nablus district

Nablus governorate is the home to 336380 inhabitants including three refugee camps and surrounding villages. The estimated population of the city in 2006 are 134.116 according to Palestinian statistic, refugee camps 35387 and surrounding villages 166877. There are 41 primary health care centres owned and supervised by the MOH in Nablus (PCBS 2006).

1.6 Target and comparable localities

The community mobilization (CM) project is implemented in twelve villages over one year, these are: Huwwara, Assawieh, Oreaf, Bureen, Beit-Foreek, Beit-Dajjan, Balata-

Albalad, Deir-Alhatab, Albathan, Yaseed, Talloza and Sabstia (total population 40074 according to PCBS, 2006).

These villages have more than 700 cases of diabetes, and this project aimed to increase awareness for people which push up people to utilize to the medical service. There are other 29 governmental primary health care centers in Nablus area can be used to compare with the target centers. (Total populations are 98921 according to PCBS, 2006).

1.7 Primary Health Care Centers Services (PHCs)

The Alma Ata Conference defines primary health care as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally, accessible to individuals and families in the community by means of acceptable to them, through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which it is the central function and the main focus and of the overall social and economic development of the community" (WHO report 2000, p.4).

Governmental PHCs are the governmental institutions that provide diagnostic and preventive health care. The health center is the location where primary health services are provided. It usually has a nursing team and a general practitioner with some specialized clinics (diabetic services) and a laboratory. It provides mother and childcare with vaccines and other services such as diabetic services and health education.

In this research study, all PHCs that provide diabetic services at Nablus district excluding city center were the target setting for participants to fill the questionnaire. There are four centers included in this study; two of them implemented community mobilization (Huwwara and Asira) and two other did not implement community mobilization project. The primary health care is at the heart of the plans to reform, and develop health services in Palestine. An integrated package of essential PHC services available to the entire population will provide the solid of comprehensive health system. It will be possible for citizens to see what quality of primary care services they can expect to receive. It also acts as guidance for district health offices to provide these services and as a tool for quality improvement and assessment.

1.8 Types of primary health care services in selected clinics

All clinics were selected in this study at level three in primary health care and public health facilities provide services through multiple activities and programs including, non–communicable disease program, mother and child health care, immunization , family planning, dental care, laboratory and health education. The staff includes; general physician, two nurses, one laboratory technician and medical specialist.The following table identify level three from other PHC levels.

Table 2: Levels of PHC Clinics at the Palestinian MOH

Clinic Level	Number in West Bank	Staff			Laboratory and Radiology Facilities	Services		**Number of Population Served**
		General Practitioner (GP) & Specialists	Nurses	Health Workers		Preventive	Curative	
Level I	83	1 GP Visit twice a month	1 nurse Visit twice a month	1 health worker	None	* Mother and child health care. * Immunization.	First aid	<1000 people
Level II	201	1 GP 2-4 days per week	1 nurse	None	Laboratory in some clinics	* Mother and child health care. * Immunization.	GP medical care,	1000 – 3000 people
Level III	86	1 GP	2 nurses	None	Laboratory	* Mother and child health care. *Immunization * Family planning * Dental care * Health Education	* GP * Medical specialist	> 3000 – 10000 people
Level IV	12	> 1 GP Specialists	> 2 nurses	None	Laboratory and Radiology	* Mother and child health care. *Immunization * Family planning * Dental care * Health Education	* GP * Medical specialist * Gynecology and Obstetrics * Emergency Medical Services	> 10000 people

Source: Ministry of Health, 2005; PHIC, 2010.

1.9 Chronic disease interventions and services provided

This intervention includes the following: Screening and early detection. Diagnosis and classification. Management. non-pharmacological treatment and Health education and awareness as well as Promotion of healthy lifestyle. Pharmacological treatment. Follow up and monitoring for complications, compliance of treatment and side effect one of the important function of PHC.

1.10 Problem statement of the study

This is the first time that MoH implement the community mobilization within its PHC system, and the use of new strategies through implementing this project. Community mobilization strategies model is still a new concept and incomprehensible for the staff and patients in the Ministry of Health, especially in the primary health care centers in terms of objectives strategies and their effect on the quality of service provided at these centers and their impact on patient satisfaction. The Ministry of Health discloses that these new tools are imperative and inevitable and require action on awareness and training among its staff or team members of community mobilization for them to have greater expertise in this area in collaboration with financiers to such programs.

There is no adequate information about the impact of community mobilization strategies on the satisfaction of diabetic patients receiving health services in the project intervention areas compared to similar comparable clinics in other localities. There is lack of understanding and appreciation to the importance of employing community mobilization and how this can impact positively the level of satisfaction of patients. The lack of such information and evidence if achieved can be great policy significance in all primary health care services. Patient satisfaction is as important as other clinical health measures and is a primary means of measuring the effectiveness of health care delivery.

Measures of patient satisfaction are used to compare health care programs, to evaluate quality of care, and to identify which aspects of a service need improvement. In addition, patient evaluations can help to educate medical staff about their achievements as well as their failure, assisting them to be more responsive to their patients' needs.

1.11 Justification of the study

Community mobilization is decisive to assess the performance of the Ministry of Health in the services provided in primary health care and determine health community priorities through community involvement community mobilization can take advantage of the programs that have been applied abroad the country while this is misplaced and not subsisted in the Ministry of Health to make the change and the

development of policies vital more in the applicable projects and take advantage in other projects.

Fitzpatrick, 1997, denoted that there are three reasons why health professionals should take patient satisfaction seriously as a measurement:

Firstly, there is convincing evidence that satisfaction is an important outcome measure. It may be a predictor of whether patients follow their recommended treatments, and is related to whether patients reattend for treatment and change their provider of health care. Evidence has also begun to emerge that satisfaction is related to improvements in health status.

Secondly, patient satisfaction is an increasingly useful measure in assessing consultations and patterns of communication (such as the success of giving information, of involving the patient in decisions about care and of reassurance).

Thirdly, patient feedback can be used systematically to choose between alternative methods of organizing or providing health care .

Improving the quality of patients care in PHCS is a vital and necessary activity, therefore we are carrying out this study for PHCS in Nablus trying to study patient satisfaction with services and determine the variables that affect on satisfaction after implementing CM strategies in these centers, to coming up with recommendation for PHC managers and decision makers, and help them to evaluate these strategies and producing data that can help them to identify and solve problem.

Patient satisfaction is an individual's state of being content with the care provided in the health system (Anderson, 1999). And since community mobilization effective was not examined its influence on diabetic patient satisfaction.

1.12 Overall aim of the study

To explore the effectiveness of community mobilization strategies on diabetic patient satisfaction with selected governmental health clinics in Nablus district .

1.13 Specific objectives of the study

1. To compare difference of services between governmental clinics that utilized CM strategies with other governmental clinics did not utilize community mobilization.
2. To compare selected KAP of patients who received diabetic education, communication and information with patient received similar services in other comparable governmental clinics.

3. To compare patients satisfaction with the services received, participation rate in planning and designing health services, utilization services, access, privacy, and quality of care in the intervention clinics exposed to community mobilization compared with patients in other control comparable government clinics.

1.14 Research Questions

1. Is there a difference in quality services between those clinics that received CM strategies and those clinics that did not utilize CM intervention?

2. . Is there a significant difference in the satisfaction with the knowledge gained by patients who were exposed to diabetic education, communication and information with other comparable governmental clinics not exposed to community mobilization strategies?

3. Is there a difference in the patient utilization (services provided) of services between patients exposed to community mobilization strategies and those patients who were not exposed to community mobilization strategies?

4. Is there a significant difference in the patient satisfaction with access to services in the target clinics exposed to community mobilization and patient satisfaction with accessibility to services in other clinics not exposed to community mobilization strategies?

5. Is there a significant difference in the patient satisfaction with the waiting time of services received by diabetic patients in communities exposed to community mobilization and patient satisfaction with waiting time in other patients not exposed to community mobilization strategies?

6. Is there a difference in the patient participation rate in planning and designing health services between patients exposed to community mobilization strategies and those patients who were not exposed to community mobilization strategies?

7. Is there a significant difference in patients satisfaction with the cleanliness in the clinics exposed to community mobilization compared to patients in other comparable government clinics not exposed to community mobilization strategies?

8. Is there a significant difference in patients satisfaction with privacy in the clinics exposed to community mobilization compared to patients in other comparable government clinics not exposed to community mobilization strategies?

1.15 Study variables

1.15.1 Independent variables:

- Age
- Gender
- Marital status
- Educational level
- Income
- Health insurance
- Center name
- Health status
- Center choice
- Diabetic history
- Number of visits
- Beginning of treatment

1.15.2 Dependent variables: This included the following:

- Quality of services.
- Cleanliness.
- Waiting time .
- Services delivered.
- Privacy.
- Accessibility.
- Learning and communication.
- Community participation rate.

1.16 Limitations of the study

1. Possible patients' refusal to participate or feel uncomfortable during the study.
2. Difficulty in identifying comparable government clinics and communities that match the characteristics of communities exposed to community mobilization.
3. Lack of baseline studies to assess community mobilization process prior to this project.
4. The financial limitation since the study was self-funded.

1.17 Summary

This introductory chapter provided an overview about community mobilization and primary health care, also an overview of the study aim and objectives that explored the effect of community mobilization strategies on patient satisfaction with governmental health services provided to diabetic patients PHC centers in Nablus district and the factors that affect community mobilization. This chapter also included background information about the patients satisfaction, and included questions problem statement, justification, and limitations of the study.

Chapter Two: Literature Review

2.1 Introduction

This chapter reviews national and international studies conducted in the area of community mobilization strategies. A comprehensive search was employed to uncover theoretical and research work related to the study concepts. Internet search, previous master thesis, books and journals were reviewed in regard to exploring the effect of community mobilization strategies on diabetic patients satisfaction with governmental health services provided to diabetic patients.

Community mobilization is a continuous process in society aimed at bringing a society together for the purpose of generating ideas in relation to the problems they face or meeting their needs with the help of a facilitator. Mobilization aims at achieving the following: creating awareness and empowering the community to identify their problems, prioritize them, suggest interventions to solve them and the means of sustaining such interventions. It can also be referred to a process aimed at enticing adequate community participation of stakeholder community in the project management activity process including planning and design, implementation, monitoring and evaluation (Karim, 1998; Memon, 2004; Mclover, 2000; Michau and Naker, 2003).

Community participation refers to a phenomenon of empowering people to mobilize their own capacities, be social actors rather than passive subjects, manage their resources, make decisions and control the activities that affect their lives (Chambers, 1983; Nsibambi, 1997; Bartle, 2004).

Community contribution refers to the ideas from the people in the community towards a specific community policy or both ideas and materials the communities give towards the implementation of community policies or interventions (Suchman, 1967; Rodinell, 1981; Bourne, 1984; Beck, 1987).

2.2 Historical background about community mobilization

In the past two decades, there had been a substantial increase in the attention paid to patient-reported outcomes in health-care research and clinical practice. Patient satisfaction, in particular, is increasingly the focus of research and evaluation of medical treatments, services and interventions. Satisfaction is achieved when the patient's perception of the quality of care and services that they receive in healthcare setting has

been positive, satisfying and meets their expectations. A satisfied patient will recommend center‘s services to friends and family. While a satisfied patient may express that satisfaction to four or five people, a dissatisfied one on the other hand will complain to twenty or more. Also, satisfied patients are more likely to co-operate with treatment. Organization at the present time is concerned with satisfying the users of its products or services, they are known as clients, customers, consumers or patients. Satisfaction interferes with similar themes such as happiness, contentment and quality of life. Satisfaction is not some pre-existing phenomenon waiting to be measured, but a judgment people form over time as they reflect on their experience (ACQUIRE project, 2006).

Community mobilization, a key strategy for increasing demand for and use of health services, is a process that helps communities to identify their own needs and to respond to and address these needs. Gaining the participation of community members can help providers raise awareness both of health issues at the community level and of social and cultural issues that may promote or inhibit use of information and services, as well as improve clients' understanding of the methods or services being offered. Specific barriers to service access and use can be addressed and service utilization increased. Community mobilization promotes consideration of the needs of specific populations and localities. In particular, underserved populations, such as youth and men, can be reached more effectively through community mobilization. Mobilization also leads to greater sustainability, as communities are empowered and capable of addressing their own needs. A number of studies show a sense of ownership is crucial in building sustainability. (Grabman, and Snetro, 2003).

2.3 Patient satisfaction

Patient satisfaction is not a clearly defined concept. Most often satisfaction is defined differently by different individuals as a consequence of varying backgrounds and experiences. Although attempts were made to explain how patients become satisfied, there is not yet any one universal model explaining patient satisfaction (Ware, 1978).

It has often been argued that patient expectations about health care are the main antecedents to patient satisfaction. Patients are said to enter the health system with a variety of characteristics, attitudes and prior experiences with the services. These, together with the knowledge and information they gained from their previous utilization of the services, will help them define their needs for health care. Numerous

questionnaires designed to measure the concept, and several thousand studies, very few published articles have been concerned with defining "patient satisfaction" or providing any conceptual model to inform its measurement (Williams, 1995).

Patient satisfaction (PS) is defined as "multiple evaluation of distinct aspect of health care which are determined in some ways by the individuals' expectations, attitudes and comparison process" (Pelz, 1985). It represents, in general, the patients overall assessment of physicians, delivered care, structure, process and outcome of their care. While numerous factors affect patient satisfaction including financing and organization of care, waiting time, health status, and the patient's own expectations, the provider of care remains a key element in patient satisfaction (UNICEF, 2004).

Physicians' gender, practice behavior such as providing health education, performing a physical examination and interactive skill have been shown to affect patient satisfaction. It has been shown that PS can serve as a predictor of utilization of health services, continuity of care and overall patient compliance. It has also been suggested that patients may be more satisfied with the provided health care services which meet their expectation. If the health provider fails to perform in a way that conforms to patient's expectations, it will be reflected negatively on PS and may increase the frequency of doctors shopping. Studies, especially those carried out in developing countries, have consistently shown a good level of PS in spite of poor services .Such an odd finding was hypothesized to be due to the low level of expectation of health care services (Mawajdeh, 1995).

Others, however, believe that patient satisfaction is a more complex phenomenon, and results from interactions between the goals of the patients seeking health care in each instance, the level and nature of their past experience with health services, the socio-political ideologies on which the current health system is based, and the images of health held by the patient (Calan, 1988).

Some believe patient satisfaction is a relative judgment resulting from comparing perceptions of current health status and aspirations. So that patient satisfaction can be described as: "The extent of an individual's experience compared with his or her expectations". Also patient/client satisfaction is an attitude -a person's general orientation towards a total experience of health care. Satisfaction comprises both cognitive and emotional facets and relates to previous experiences, expectations and social networks (Wright, 1985).

2.4 Factors affecting patient satisfaction

Ware et al., (1983), argued that patient characteristics are the determinants of satisfaction, whereas interpersonal manner, technical quality, accessibility, cost, efficacy, continuity, the physical environment and availability of resources are the components of satisfaction. Previous measurements of patient satisfaction show that the majority of consumers, usually 80% or more, express overall satisfaction with their care, with few respondents responding negatively to any given item (Mohon, 1996).

Patient expectations are defined in terms of patients' needs, requests or desires prior to seeing the doctor. Meeting patient/client expectations is assumed to play a role in the by which an outcome can be said to be satisfactory or unsatisfactory. Expectations have important influence on the patient/client's overall measurement of satisfaction with a health care experience. Patient/client satisfaction is influenced by the degree to which care fulfils expectation. Availability of customer needs and expectations will increase his satisfaction (Mohan, 1996).

Some literature however suggest that a link between satisfaction and fulfillment of patient/client expectations is not necessarily the case, since it is possible that the patient/client's evaluation of a service may be largely independent of actual care received (Williams, 1994).

Elder respondents generally record higher satisfaction (Pope and Mays,1993). Age is a well known determinant of the patient satisfaction index (PSI) with older patients scoring more highly and being more satisfied than young and middle aged patients. On the contrary, Jenkinson., et al (2002), found age was only weakly associated with satisfaction.

The extent to which a patient health status correlates with patient satisfaction has been investigated, but results are inconsistent. Some studies found that perceived health status is one of the factors which were found to be positively associated with satisfaction with the quality of health care (Patrick, 1983).

Sicker patient/clients and those experiencing psychological stress are less satisfied, poor health and pain decreased patient satisfaction (Marshal, 1996).

Zapka., et al (1995), found that healthier patients were more satisfied but also, on the contrary that patients with chronic illness were more satisfied. While Hsieh and Kagle (1991) found that health status was not a strong predictor.

Crow., et al (2003) in their review of literature identified that satisfaction was linked to prior satisfaction with health care and granting patient/clients' desires. Past experiences of the patient, family or acquaintances with health care what other people have told them about a particular disease, practitioner, or institution impacts a person's perceptions, expectations and response to treatment, there is consistent evidence across settings that the most important health service factor affecting satisfaction is the patient/client-practitioner relationship, including information and technical competence, excessive waiting is perhaps the greatest irritation and dissatisfaction. Several studies have been documenting the negative association between increased waiting time and patient satisfaction with primary care.

Anderson., et al (2002), found that time spent with the physician is most powerful determinant of overall patient satisfaction. However, the combination of long wait times and short visit times produced the lowest level of patient satisfaction observed in the study, and suggests that both measures are important.

Waiting times have been shown to be important to patients, with those who see a doctor more quickly increasingly likely to rate the care they received as excellent or very good (Commission for Healthcare Audit and Inspection, 2005). A review by Trout., et al (2000), found that perceived waiting time, but not necessarily actual waiting time, was inversely associated with satisfaction. However, the authors conclude that as the reviewed studies were cross-sectional, causality could not be established.,

Taylor and Benger (2004), examined the factors that influence patient satisfaction in the Emergency Department, they commented that the most frequently assessed factors in the literature were actual and perceived waiting time. Their review found that three service factors influence patient satisfaction; the interpersonal skills and attitudes of staff, the provision of information or explanation to patients, and waiting times. However, they were unable to determine the relative importance of these factors.

Choice of service provider is associated with higher satisfaction. Evidence about the effects of gender, ethnicity and socio-economic status is equivocal due to the small amount of literature available on each. Some studies have indicated that female report greater satisfaction than male, while other studies have contradicted this finding (Crow., et al, 2003).

Privacy has become one of the most important ethical issues of the information age (Mason, 1986). It (privacy) has been defined as "the claim of individuals, groups or institutions to determine for themselves when, how, and to what extent information about

them is communicated to others" (Westin, 1967). Culnan and Armstrong (1999), concurs that privacy is the ability of an individual to control the conditions under which personal information is collected and how it is used. The scope of this research pertains specifically to information privacy which is defined as the ability to control over how personal information is acquired and used (Culnan and Bies, 2003). It is differentiated from data privacy that is more focused on disguising data identity such as anonymity, unlinkability, unobservability or pseudonymity. Recent research considers patients' perspectives on the services they receive an essential part of understanding and assessing quality of care (Williams., et al, 2000). Patients' perceptions are shaped by their cultural values, previous experiences, perceptions of the role of the health system, and interactions with providers. Their perceptions affect how patients view the risks and benefits of care (Kelley and Boucar, 2000).

Patient satisfaction may not necessarily mean that quality is good; it may only indicate that expectations are low. One woman in Bangladesh noted, "Even though the [providers] behaved badly, I have to be content. We are lucky if we can get the free medicine that they give out at the clinic.... We are poor people; how are we going to get better treatment than this?" (Schuler and Hossain, 1998).

Patients may also say that they are satisfied with care because they want to please the interviewer, worry that care may be withheld in the future, or have some cultural or other reason to fear complaining. Many patients have limited options and have never experienced any other standards of care. Further, educational and class differences between patients and providers often limit patients' ability to assess services (Kols and Sherman, 1998).

Variations in experiences and social environments mean that different patients define quality in different ways, but there are several common trends in what patients consider key elements of quality services. Patients who have difficulty with accessibility are less satisfied and awareness about the services provided by primary health centre is assessed only in the community survey (Shikiar and Rentz, (2004). They have proposed a three-level hierarchy of satisfaction, which includes:

1. Satisfaction with health-care delivery (i.e., the clinic or service, including issues of accessibility, clinician-patient communication, quality of facilities).
2. Satisfaction with treatment (i.e., with medication and other aspects of the treatment, e.g., dietary and exercise recommendations).
3. Satisfaction with medication (i.e., focusing on the medication).

Patient satisfaction is now a critical variable in any calculation of quality or value and therefore in the assessment of corporate/individual accountability. It is a legitimate and important measure of quality of care.

The literature on patient satisfaction with primary care indicates that key attributes of health care valued by patients are patient-centered, including time spent with the physician, willingness of the physician to listen to the patient, and expectations for treatment. An anecdotal source of dissatisfaction with health care reported by patients is having to wait a long period of time in the office. Several studies have documented the negative association between increased waiting time and patient satisfaction with primary care (Anderson, 2007).

However, waiting time is but one aspect of health care that patients' value, and its centrality to patients' assessment of their primary care visit compared to other aspects of the health care experience is uncertain. Time spent waiting is a resource investment by the patient for the desired goal of being seen by the physician and therefore may be moderated by the outcome. In a typical practice, patient waiting time and time spent with the physician are to some degree counter-controlled. Since the amount of daily clinic time per physician is a fixed asset, portioned out by patient demand or volume, the more time on average a specific physician spends with an individual patient, the longer will patients have to wait to see that physician. This leads to the testable hypothesis that the effect of waiting time on patient satisfaction must be considered in the context of time spent with the patient to be meaningful. If this hypothesis is correct, physicians who fall behind in their patient schedules and end up having both long patient wait times and shorter visits with the patient will achieve significantly lower patient satisfaction scores than physicians who have both long patient wait time and extensive patient visit times (Dansky, 1997; Huung, 1994; Zollar, 2001; Bar-Dayan, 2002).

The Institute of Medicine recognizes the problem of prolonged waiting times. This group has recommended that at least 90% of scheduled patients should be seen within 30 minutes of their scheduled appointment time (O'Malley .,et al ,1993).

In one study, Kurata compared patient and provider satisfaction with medical care and waiting time in a large family practice residency program. While 97% of patients were satisfied with their medical care, approximately 8% of patients and 22% of providers were dissatisfied with waiting times. An estimate of waiting times by dissatisfied patients

was 41.8 minutes (Kurata .,at al, 1992).

Emergency rooms are notorious for long waiting times. Fernandez found that while 90% of patients are willing to wait up to one hour, 60% of the study patients cited prolonged waiting time as the major reason for leaving without being seen by a provider. In one pediatric emergency room study Dos Santos found that 62% of patients who left without seeing a provider left because of a long waiting time (188 minutes). Another pediatric emergency room study by Hanson confirmed this finding and stated that "the waiting time was presented as the main reason for walking out". The average waiting time reported by Bamgboye in the emergency room department was 148 minutes (Bamgboye and Jarallah, 1994).

Cupit reported that 55% of all clients seen in one ambulatory care setting waited more than one hour to see the provider. Reti studied similar patient waiting time characteristics. Reti looked at the effect of 407 patient arrival times on patient waiting times to see a family physician. Ten percent (10%) arrived on time, 66% were early, and 24% were late for their appointments. The 10% of patients who arrived on time for their appointment waited an average of 17.58 minutes. The 66% of patients who were early waited an average 23.30 minutes compared to a corrected early waiting time of 15.20 minutes. The 24% of patients who were late waited an average 14.56 minutes. Early arrivals were on average 10.39 minutes early, with 33% more than 15 minutes early and 3% more than 30 minutes early. Late patients were on average 9.47 minutes late with 33% more than 15 minutes late, and 4% more than 30 minutes late. Booked patients waited an average 20.68 minutes compared to acute patients waiting an average 24.39 minutes (Reti, 1994).

In South Africa, there is a paucity of reliable and valid satisfaction measures for specific populations. In addition, no local studies have investigated the relationship between the components of patient satisfaction and health status. In order to rectify this state of affairs, complement international research and provide a credible analysis of satisfaction findings, we developed and tested a patient satisfaction scale for diabetic outpatients. Based on Donabedian's structure, process, and outcome model, South Africa study was conducted to identify the underlying dimensions of patient satisfaction and determine the effects of demographic characteristics and health status on these dimensions. Patient satisfaction is regarded as one of the desired outcomes of care, an element in health

status, a measure of the quality of care, and ‘as indispensable to assessments of quality as to the design and management of health care systems (Donabedian, 1988).

It has been proposed that the effectiveness of health care is determined, to some degree, by satisfaction with the services provided. Support for this viewpoint has been found in studies that have reported that a satisfied patient is more likely to utilize health services, comply with medical treatment, and continue with the health provider. Various studies have shown that satisfaction is related to technical and interpersonal competence, more partnership building, more immediate and positive non-verbal behavior, more social conversation, courtesy, consideration, clear communication and information, respectful treatment, frequency of contact, length of consultation, service availability and waiting time (Weisman and Koch, 1989).

Measurement of patient satisfaction fulfils three distinct functions: understanding patients' experiences of health care, identifying problems in health care and evaluation of health care. Evaluation is regarded as the most important dimension. Donabedian,1982 has provided a model based on structure, process, and outcome for evaluating the quality of health care. Structure refers to the attributes of organizations delivering care and the conditions under which care is provided, process relates to the professional activities associated with providing care, and outcome denotes the effects of care. It is noteworthy that outcome includes health status, improvements in knowledge, changes in behavior, and patient satisfaction with care. Donabedian regards satisfaction/dissatisfaction as a ‘patient's judgment on the quality of care in all its aspects, but particularly as concerns the interpersonal process’.

Implicit to Ware et al.,'s ,1983 definition of patient satisfaction as ‘a multi-dimensional concept, with dimensions that correspond to the major characteristics of providers and services’, is Donabedian's interpersonal process and organizational attributes.

Ware et al argued that patient characteristics are the determinants of satisfaction, whereas interpersonal manner, technical quality, accessibility, cost, efficacy, continuity, the physical environment, and availability of resources are the components of satisfaction.

Most studies on satisfaction have found that older patients report higher levels of satisfaction than younger patients. In general, gender does not affect levels of satisfaction. The evidence on the relationship between educational attainment and satisfaction is ambiguous. As expressed by Sitzia and Wood, ‘there is a notable lack of

supportive evidence from the United Kingdom for this determinant, and it may be that other factors—such as income—are confounding the U.S. evidence' (Sitzia and Wood, 1997).

Although age is related to satisfaction, this relationship is confounded by health status or health-related quality of life (*Cohen* 199,6*).*

Whereas Williams and Calnan, 1991, found no significant relationship between health status and satisfaction in either primary or hospital care settings, Cohen,1996, reported that pain and psychosocial health status, adjusting for age, was significantly related to lower satisfaction with health care. Cohen's findings suggest that patient satisfaction is susceptible to change in response to organizational, clinical, and interpersonal treatment.

Results from previous studies on the relationship between health status and patient satisfaction have found that patients in better health tend to report greater satisfaction with their health care than patients in poor health (Patrick et al., 1983; Hall et al.,1983). Some studies have shown that mental, but not physical, health status is associated with patient satisfaction (Marshall et al., 1996). In contrast, Da Costa *et al* (1996) found that general satisfaction was significantly related to both physical ($r = 0.17$, $P<0.05$) and mental ($r = 0.20$, $P<0.01$) health status. The research design used by Da Costa *et al*. did not permit a causal inference on the direction of the relationship between health status and patient satisfaction. However, Hall *et al*.,(1993) using a longitudinal design, found evidence to support a unidirectional causal link between earlier self-reported health status and later patient satisfaction.

Although healthier patients are generally more satisfied with their care than less healthy patients, there is a lack of clarity on the relationship between health status and the various components of patient satisfaction. Identifying these relationships would assist in making more rational quality improvement strategies, thereby contributing to the increased effectiveness of health care (Wesatway et al., 2003).

Susie Linder Pelz, 1982 in her review of the patient satisfaction literature, offers the following definition: patient satisfaction is "positive evaluations of distinct dimensions of the health care". (The care being evaluated might be a single clinic visit, treatment throughout an illness episode, a particular health care setting or plan, or the health care system in general).

The suggestion by Linder-Pelz is that satisfaction must be understood within the context in which a variety of elements may be more or less satisfying to the patient. She

identified 10 elements that can be used to determine satisfaction: Accessibility/convenience, availability of resources, continuity of care, efficacy/outcomes of care, finances, humaneness, information gathering information giving, pleasantness of surroundings, and quality.

Various dimensions of patient satisfaction of health care centers have been identified, as well as from medical care to interpersonal communication. Well-recognized criteria include responsiveness, communication, attitude, clinical skill, comforting skill, etc.

Fan et al (2004) found continuity of care is strongly associated with higher patient satisfaction. This suggests that improving continuity of care may improve patient satisfaction with providers as well as with their health care organization, found about 82% of the respondents were aware of the availability of primary health centre. Despite this high awareness, only just over half (54.9%) of those who were aware of the primary health centre had ever utilized the services. Some of the major reasons for non utilization of services were more faith in quacks, inconvenient timing of the primary health centre, long queues, non availability of all drugs, and investigations.

Thus there is a conscious effort on the part of all stakeholders to constantly monitor the quality of healthcare service provided to patients in order to determine the need for improvement or innovation. The primary concern of this effort is the improvement of the present health condition of the people and the ethical concept of promoting life itself due to which, significant efforts and concerns are always given for the quality of healthcare services.

In order to affect this laudable goal of assessing the quality of healthcare provided by different concerned institution, tools such as surveys are developed and used. Surveys that assess the level of satisfaction derived by patients from health care providers could be helpful for improvement of services. On a daily basis, feedback from patients could give insight on the kind of service they experience in hospitals or other medical facilities (Kowalczyk,2005 Fahy ,2008 Medicare, in an effort to understand the needs and experience of patients, came up with the patient satisfaction survey program(University Affiliation 2008).

The complexity and rising prevalence of chronic diseases such as diabetes are among the factors that call into question the traditional lack of collaboration among healthcare providers and organizations Chronic disease treatment challenges, such as those posed by diabetes, foster the collaborative trend that, since the early 1990s, has swept the healthcare industry in North America under the label “integrated delivery systems”.

To promote behavioral changes in patients, encourage empowerment and ultimately foster self-care, the clinical team from the community health centre created an assessment tool based on the Stages of Change model of behavior acquisition. Upon entry into the project, each patient was evaluated in six different spheres pertinent to diabetes: general knowledge about the disease, nutrition, physical activity, foot care, medication use and emotional stress. According to this first evaluation – which was very time-consuming, lasting about 90 minutes on average – an individualized service plan was elaborated, detailing provision of services in response to identified patient needs. Such a plan could include either individual or group sessions that provided direct care, such as foot care or nutrition counseling, or education in one of the six spheres. The evolution of diabetic patients through the different stages of diabetes-related health behaviors was monitored and assessed periodically by the nurse case managers. However, fragmentation in service delivery prevailed.

Health service studies concentrate on factors influencing access to health care, which they commonly defined as utilization rate. They apply determinant's models and consider access as a general concept summarizing a set of more specific dimension, such as availability, affordability, accessibility, adequacy, and acceptability. Although they take into account demographic characteristics of health service users, their knowledge about the disease, and, more recently, wealth as measured by household assets. Health services studies tend to pay more attention to the supply than the demand side they search for policy Intervention to reduce supply barriers and improve the delivery of services, including availability of health facilities, equipment, and qualified staff, staff skills, and protocols of diagnosis, treatment, and quality of care. Moreover, they are less oriented towards health-seeking processes. Interventions on demand side are commonly limited to information, education and communication campaigns.

In 1978, the declaration of Alma –Ata sought the commitment of the member of the World Health Organization (WHO) to the target of health for all (HFA) by the year 2000. The declaration identified primary health care (PHC) as the key to attaining HFA part the global quest for social and economic development in a spirit of social justice. The heavy burden of sickness, the high cost of health services coverage called for a bold new approach, PHC offered a rational and practical means for both developing and industrialized nations to work towards the health for all goal. The major concepts of PHC approaches consist of community participation appropriate technology, inter scrotal collaboration and the mobilization of local resources.

This study emphasizes the work for changes that will benefit the social, emotional, financial and physical needs of citizens, placing it in a context of equity, social justice, democracy , respect for human rights, the 'prioritization of problems and needs made by the citizens, what is needed to mobilize the community, who needs to be involved. When essential elements and conditions come together, a true sense of community evolves; one that inspires, energizes and rewards members of as they resolve joint problems. Leaders take a positive stand. "Community" becomes redefined more than a place and more than the elements that divide people. It becomes the way in which people live and work together.

Community participation in health may be defined as the process by which members of the community, either individually or collectively: a) develop the capability to assume greater responsibility for assessing their own health needs and problem; b) plan and decide on solution; c) create and maintain organization in support of these efforts; and d) evaluate the effects and about necessary adjustment in goals, targets and programs ongoing basis. The most dimension of community participation is power and its distribution between citizens and their leaders or political structure (Windle and Cibulka,1981).

The principle of community participation is one of the cornerstones of the primary health care strategy for achieving the goal of health for all by the year 2000 as enunciated by the declaration of Alma-Ata (WHO, 1978) and of the various specific goals and targets set by many countries and by the international community collectively (pan American health organization (PAHO), 1977; WHO, 1985). A number of countries have constitutionally recognized the importance of community/public involvement in social policy development and decisions.

In the course of its development, community participation becomes: a) active when the people take part in its various stages; b) conscious, they fully understand the problems, translate them into felt needs, and work to solve them; c) responsible , when they commit themselves and decide to move ahead in full awareness of the consequences and their obligations; d) deliberate, when they express their voluntary resolve; e) organized, when they perceive the need to pool their efforts to attain the common objective; and f) sustained, when they band together permanently to solve the various problems of their community. Thus, with so many problems and obstacles to confront, those involved in promoting and developing community participation have an enormous task. Whether they doctors, nurses, supervisors, community health workers, community promoters, or the

actual participant themselves, they need to have in hand as many techniques as possible to solve these problem. This study sheds some light on these core issues for Botswana.

At the local level, the regional health team were made operational under the district/Town councils and called district health team. While they were under the executive and administrative control of the councils, the ministry of health, which maintained overall accountability for health in the country, continued to supervise, assist and advise district health services to ensure that ministry policies were followed and acceptable standers of care were maintained.

To support primary health care and community participation at the community level the ministry of health, together with the ministry of local government and lands, put in place support structures to foster community involvement. These include: the family welfare educator cadre, village health committees, village and district extension team, village development committees, and district development committees. It also mounts educational programs like the community leaders health seminars. All of these are recognized as major factors in the attainment of community participation and primary health care during the sixth national development plan.

The ministry of health identified research priorities for the six year of the national development plan in order to assist policy makers, planner, and developers by providing them. With objective data to guide the implementation of PHC, the research priorities include: a) community involvement and structures, for example village health committees and family welfare educators; b) intersectoral coordination; c) utilization patterns of health care and health facilities; d) staff utilization; e) costing of primary health care; f) traditional health care; g) research on specific groups and conditions; and h) the role of non –governmental organizations.

In response to these research priorities, there have been three major health care studies conducted in Botswana: a) the continuous household integrated programme survey; b) the national health status evaluation programme; and c) the Botswana family health survey. All of these studies focused on evaluating the implementation of the primary health care system and on identifying and developing indicators to monitor and evaluate the health of individuals as a result of the various health services. The national health status evaluation programme was a multidisciplinary project involving the Botswana government, and the University of Botswana, the national institute of research, and the Norwegian agency for development. The program comprised a number of different studies all addressing specific areas. Two of these studies have major relevance to the proposed study: a) the

village health committee study (Owuor- Omondi,et al., 1987), which assessed the committees as viable instruments of community mobilization for primary health care, and b) the family welfare educators study (Knudsen ,et al .,1988), which examined methods for improving the community focus of the family welfare educator cadre.

Hulka and her associates attempted to undertake the initial steps in the conceptualization of the patient satisfaction concept. These researchers defined "satisfaction" as the patient's "attitudes toward physicians and medical care." More specifically, a composite index of an individual's evaluative judgments concerning the quality of medical care received from physicians, nurses and other relevant sources is hypothesized to represent the individual's level of "satisfaction". Within the patient satisfaction literature, this conceptual definition has been widely accepted. Several researchers have attempted to develop operational measures for the patient satisfaction concept. Hulka, Zyzanski, Cassel and Thompson (1970) proposed one of the earliest operationalizations; a forty-two item measure for assessing the three dimensions of the patient satisfaction concept. Of the three dimensions, only the personal quality dimension had an alternate forms reliability greater than 0.7. For the professional competence and the access dimensions the reliability was 0.63 and 0.43 respectively. When different samples were utilized, similar levels of reliability were found by Hulka and her associates. In particular, the access dimension yielded consistently poor values for consistency of response

More recent research has challenged this conceptual definition from at least three perspectives. The first perspective notes that the episode (or situation) is a major source of variation in "satisfaction" evaluations. Thus, it posits that patient satisfaction is better defined as an individual's evaluation of the quality of care in a specific medical-care situation; and not just as a global attitude aggregated across episodes. These researchers note that individual patient-physician encounters are basic unit of medical care and, therefore, assessing satisfaction for "individual encounters may contribute so a fuller understanding of the nature of physician-patient relationship".

Second, researchers in the consumer satisfaction literature take issue with the definition of satisfaction as a cognitively based evaluation of product/service attributes. Instead, these researchers contend that satisfaction is an emotional or affective response to a product or service use (or consumption) situation. This position does not imply that patients do not make cognitive evaluations. Rather, it distinguishes both, from conceptual and empirical standpoints, between cognitive and affective evaluations. More specifically, cognitive evaluations are treated within the framework of (disconfirmed)

expectations. By contrast, effective evaluations are posited as a distinct concept which results from the preceding cognitive evaluations. However, patient satisfaction researchers have argued that attribute based "satisfaction" judgments are more appropriate because they allow a richer measure of patients' satisfaction level and identify areas (i.e., attributes) which contribute to satisfying or dissatisfying experiences.

Third, Ross et al. (1987) argue that restricting patient satisfaction to perceptions of the "quality" of health care received is an "inherent weakness." These researchers support their position by noting that a segment of "healthy but unhappy" patients has been found in several empirical studies. Thus, Ross et al. suggest that the conceptualization of the patient satisfaction should be enlarged to include other evaluations (e.g., waiting time, costs, etc.) in addition to purely quality perceptions.

Ware and Snyder, 1975 proposed yet another operationalization for the patient satisfaction concept. The particular operational measure proposed had eight Likert items, and was conceptually designed to assess twenty-two dimensions of the satisfaction concept. Empirically, however, Ware and Snyder found support for four basic factors, namely, physician conduct, availability of service, continuity/convenience of care, and access to care.

More recently, Penchansky and Thomas (1981) provided an operational scale to measure the "access' component of satisfaction evaluations. These researchers posited that the access component itself is multi-dimensional. In particular, a sixteen item scale was proposed to measure five distinct dimensions, namely, availability, accessibility, accommodation, affordability, and acceptability. Using responses from a non-random sample of 287 respondents, Penchansky and Thomas found empirical evidence for the discriminant and construct validity of the proposed five dimensions of access.

Within the health care marketing literature, each of the preceding operationalization has been utilized with some regularity. For instance, Tucker and Tucker (1985) report a study in which the operational measure proposed by Hulka et al. was incorporated. In a research to examine the sources of influence used in the selection of primary care providers, Sullivan (1984) utilized the operational measure proposed by Ware and his associates. Finally, an example of a study that used the Penchansky and Thomas scale is the research by Tucker and Tucker (1985).

In addition, some researchers have tended to develop their own measures of patient satisfaction. For instance, Scammon and Kennard (1983) attempted to assess respondent's evaluations of general and specific satisfaction using 26 seven point semantic differential

items.

Likewise, Andrus (1984) reports ten items used to measure consumer's satisfaction with the service that they received at the family practice office. Unlike the preceding three operationalizations, however, psychometric properties (e.g., reliability, factor analysis, discriminant/construct validity) for such indigenous scales are usually not available.

As per A.G. Zwier and D. Clark (2001) who carried out a survey in New Zealand, age, gender, ethnicity, occupation, education and socio-economic status are some of the important variables that predict patient satisfaction. Older patients were found to be more satisfied than younger ones.

A study in Hadassah hospital in Jerusalem by Shiloh (1965) found out that patients with egalitarian characteristics were satisfied with the technical aspects of services, but complained about hospital environment, noise in the ward and cleanliness and wanted to leave hospital early. Under this domain, waiting time, attitude of support staff, hospital diet, comfort and social support will be included as other relevant and important variables in the context of present study.

Some of the main attributes that are essential in care providers for patient satisfaction are the following as per literature review. Researches; Di Matteo (1980), Hall, Roter and Katz showed that patients want physicians to have a holistic approach towards their disease. They expect physicians to talk to them, listen carefully to their problems, ask and answer questions in simple terms and ultimately help them make decisions about their care. William and Calnan (1991) said that inter-personal relationship between a doctor and a patient is one of the most important determinants for patient satisfaction. A doctor who listens and sympathizes well with patients will go a long way in satisfying them.

Suchman A. et al., (1997) pointed out that health care providers underestimate the amount of information that patients want and over-estimate the ones that they impart to patients. In one study it was found that doctors felt that they had spent about 9 minutes with their patients when in fact that they spent only about 1 minute per patient visit. Same researcher found out that doctors ignore patients' emotional health and seldom appreciated their emotional feelings even when patients brought them out. Instead of sympathizing, physicians always diverted the topic back to technical discussions.

The client satisfaction assessment could represent a part of a multidimensional approach for conducting a quality improvement intervention. This is particularly used in the client-

oriented provider efficient (COPE) method, which is a process and set of tools designed to help healthcare staff at a service delivery site to continuously assess and improve their service; to review the way they perform their daily tasks and serves as a services. It is built on a framework of client rights and staff needs. The method encourages staff catalyst for analyzing the problems they identify.

This project provides a definition of CM as "the capacity building process through which individuals, groups or organizations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other needs."For "HANAN" "mobilized community" means: Empowered women who take control of their health, the health of their families and practice improved health behaviors. It has been stated, "There isn't a day when community work ends. In a healthy community, working together for the good of the community is a constant part of everyone's lives". This suggests that rather than being an activity that is promoted by a project, CM must become a part of the community through which positive social change is not only achieved, but is also sustained. The end result of successful CM is not only a "problem solved" but the increased capacity to successfully address a community's needs and desires.

In 2008 a study conducted in Nablus, Palestine with the objectives was to measure patients' satisfaction with services provided by hospitals at Nablus city. Factors affecting patient's satisfaction including room services, staff communications skills, physicians' explanations, technical quality of health care providers, waiting time, and availability of health services. The study aims at determining the differences of satisfaction according to socio-demographic characteristics (age, gender, income, marital status, and education level). A cross sectional study was conducted at Nablus hospitals (governmental and non-governmental), from January to March, 2008, to measure patients' satisfaction with services provided at Nablus hospitals, and to determine factors affecting patients' satisfaction including room services, technical quality and interpersonal skills of health care providers, accessibility and availability of services. A total of 365 adult inpatients were chosen randomly by a stratified random sample were interviewed using a comprehensive questionnaire to rate the level of satisfaction of services received on 5-point Likert Scale. The patients in non-governmental hospitals were more satisfied than patients in governmental hospitals. About 70.2% of respondents rated their general satisfaction with governmental hospitals as good to very good. While in non-governmental hospitals, more than 90 % rated it as good to very good. The results also indicated that older patients were more satisfied than the younger ones; females were

found more satisfied than males. In addition to this, patients with high income were more satisfied than others with low income. Also healthier patients were more satisfied than sicker patients. However, patients who were waiting long time (more than one hour) in the reception area to get a bed in the hospital, were less satisfied than the others; obstetric patients were found to be the most satisfied.

In 2011, a study was conducted in Ramallah, Palestine with the objectives were to assess married female's level of satisfaction with reproductive health care services in Ramallah district in Palestine and factors affecting patient's satisfaction including privacy of services, informativeness, gender sensitivity, technical quality of health care providers, waiting time, and accessibility of health services. The study aims at determining the differences of satisfaction according to socio-demographic characteristics (age, gender, income, marital status, and education level). A cross sectional study was conducted at Ramallah clinics (governmental and non-governmental), in the first 1-3 months of 2010 , to measure patients' satisfaction with services provided at Nablus hospitals, and to determine factors affecting patients' satisfaction including room services, technical quality and interpersonal skills of health care providers, accessibility and availability of services. A total of 300 adult female patients were chosen randomly by a stratified random sample were interviewed using a comprehensive questionnaire to rate the level of satisfaction of services received on pre tested Likert five scale questionnaire were used, six domains of satisfaction were studied for satisfaction (quality of service, informativeness, accessibility to the centers, waiting time, gender sensitivity and privacy).

The results revealed a relatively high satisfaction (64.2% satisfied and 29% were strongly satisfied) with reproductive health service provided at Ramallah from different providers; Governmental, United Nations Relief and Work Agency, and Non Governmental Organizations. the study results show that there are some leading factors of dissatisfaction attributed to a range of factors as; long waiting time to enter the examination room, gender of the service provider and privacy tools as; shutters, and screens, some of them are harder to control than others.

In relation to the type of provider, it was found that governmental organizations had the highest level of participant's satisfaction, followed by the NGOs which was ranked secondly, while the UNRWA had the lowest level of satisfaction.

The Goodman et al., (1998) publication is based on a symposium organized by the US Centers of Disease Control and Prevention on community capacity (CC) from a

measurement perspective. They define CC as: 'The characteristics of communities that affect their ability to identify, mobilize and address social and public health problems; and the cultivation and use of transferable knowledge, skills, systems and resources that affect community- and individual-level changes consistent with public health-related goals and objectives'. Ten capacity dimensions that can be 'built' in a community are: participation, leadership, skills, resources, social and inter-organizational networks, sense of community, understanding of community history, community power, community values and critical reflection.

Likewise, Laverack (2005) provides an analytical approach to the components of CM. He outlines nine domains of CM: stakeholder participation, problem assessment capacities, equitable relationship with outside agents, organizational structures, resource mobilization, links to other resources and people, stakeholder ability to 'ask why', control over programme management and local leadership. He also emphasizes the concept of 'parallel tracking', where top-down and bottom-up approaches can be harmonized in situations where agendas are initially set by outside authorities.

Accomplishments of patients' prospects (expectations) explain between 8% and 25% of the inconsistency in satisfaction. In Central and Eastern Europe, the concept of patient satisfaction was developed relatively recently.

The aim of this study was to have the first overview of patients' expectations for primary care consultations in Lithuania, and to evaluate the influence of meeting patient expectations on patient satisfaction itself ,the method used in this study was developed by Williams *et al*. for the survey. It included a questionnaire for patients consisting of three parts.

Forty (40) primary care physicians from 22 primary health care (PHC) centers attending courses at Vilnius University were recruited for the study. Twenty-eight (28) physicians worked in city PHC centers, while 12 worked in rural PHC centers. The patient sample consisted of 609 patients. The response rate was 78%. Fifty-three patients refused to participate in the study, 460 questionnaires were available for statistical analysis.

Results of this research suggest that doctor–patient contact is an important factor of patient satisfaction with health care was firstly viewed with disbelief, and supplementary verification was needed. Further reason for this was the fact that the findings of studies performed in other countries, and the methodology used, cannot always be practical to diverse health care systems due to cultural, historical or organizational differences.

The mean scores indicated that patients were moderately-to-highly satisfied with the care they received during their hospitalization. Patients who received ACNP care were more satisfied with their care than patients who did not receive ACNP care (t (116) = -4.23, p = .000). The difference between the groups' means was of a large magnitude (Effect Size (ES) = -.75).

Statistically significant differences between the two groups of patients were found on all domains of functioning. Patients who received ACNP care showed a higher level of physical functioning than those who did not receive ACNP care. Patients who received ACNP care experienced less role limitations due to physical health and to mental health. Further, patients who received ACNP care had higher levels of social functioning and mental health.

2.5 Summary

This chapter has reviewed the historical back ground of community mobilization factors affecting patient satisfaction and literatures available about the patient satisfaction studies on community mobilization and diabetic patient scarce within the Palestinian and regional context discuss this issue in the different sectors.

Chapter Three: Conceptual Framework

3.1 Introduction

The main aim of this study was to explore the effectiveness of community mobilization strategies on diabetic patient satisfaction with selected governmental primary healthcare centers in Nablus district. According to previous studies and the WHO recommendation, there are several domains of satisfaction from health care entities that were discussed in the previous chapter. In this research study, eight domains of satisfaction were assessed; the quality of service, service delivered, accessibility, privacy, waiting time, learning and communication, cleanliness and community participate while providing the service.

3.2 Operational definition of terms

Client satisfaction: Is a multidimensional concept, relating to both technical and interpersonal aspects of care, and the amenities of care (such as an attractive physical environment, and convenient location and parking). Donabedian (1980), points out that a patient's assessment of quality, expressed as satisfaction or dissatisfaction, could be remarkably detailed. "It could pertain to the settings and amenities of care, to aspects of technical management, to features of interpersonal care, and to the physiological, physical, psychological or social consequences of care. A subjective summing up and balancing of these detailed judgments would represent overall satisfaction" (p. 25).

Care: The process of protecting and looking after someone. The services rendered by members of the health professions for the benefit of a patient, or can be defined as the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions (The Free Dictionary by Farlex, 2012).

Quality of care: Focuses on the personal knowledge, skills, and expertise of the clinician rather than on other aspects of the treatment experience. Patient satisfaction, in our opinion, constitutes a dimension of care outside of the physical therapist's

immediate control. Yet, technical quality and patient satisfaction are synergistically linked to influence the outcomes of care. Ellwood and Paul imply (1986), for example, that dissatisfied patients are less likely to use professional advice, thus undermining both primary and secondary prevention. Therefore, in light of the hypothesized relationships among the technical expertise of the care provider, the experience of the person receiving the care and how that person values care, and measures of outcomes of the care provided, any comprehensive formulation of an operational definition of "quality" in health care should state that patient satisfaction is a necessary construct *(Elliot et al., 1992).*

Service quality: Involves a comparison of expectations with performance. According to Lewis and Booms (1983), service quality is a measure of how well a delivered service matches the customers' expectation. Modernization of healthcare systems and associated advances in evidence-based healthcare have raised expectations of improvements in the quality of care (Powell et al., 2003; Sheldon, 2005).

Accessibility: The capacity of individuals to obtain the same quality of service. The capacity of individuals to obtain the same quality of care. An indicator might involve waiting times, preventable admission/avoidable deaths, condition-specific utilization rates etc. Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background (Health Information RoadmapInitiative Indicators framework, 2000).

Efficiency: Maximizing benefits (or outcomes) for a given cost. Technical efficiency refers to the degree to which the least cost combination of resource inputs occur in production of a particular service, and an indicator might involve cost/activity ratios such as cost per case mix adjusted separation. Allocative efficiency refers to the degree to which maximum benefits are obtained from available resources, and an indicator might draw from frameworks for priority setting, such as program budgeting with marginal analysis (Boyce et al., 1997).

Effectiveness: The degree to which an intervention produces measurable increases in survival or improved quality of life (or improved outcomes) when applied in routine practice**,** or, the degree to which an intervention produces measurable increases in survival or improved quality of life (or improved outcomes) when applied

in routine practice. An indicator might be a measure of provider-assessed or patient-assessed outcome (Health Information RoadmapInitiative Indicators framework, 2000) (www.cihi.ca/).

Acceptability: The degree to which the service meets or exceeds the expectations of informed consumers. An indicator might be a suitable patient satisfaction survey (Health Information RoadmapInitiative Indicators framework, 2000).

Waiting time: Excessive waiting is perhaps the greatest irritation and dissatisfaction (Scott, 1999).

Communication: "The truly competent physician is the one who sits down, senses the 'mystery' of another human being, and offers with an open hand the simple gifts of personal interest and understanding" (Jenkins, 2002).

Continuity: The extent to which an individual episode of care is coordinated and integrated into overall care provision. Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organizations and levels over time (Health Information RoadmapInitiative Indicators framework, 2000).

Continuity of care: Refers to multiple concepts. Although it most commonly refers to clinician continuity (the proportion of patient visits with a given, particular practitioner), it can also refer to record continuity (availability of patient's medical information to all clinicians who care for the patient), site continuity (a patient's usual source and site for obtaining health care), the continuum of care (from beginning to the end of the healing process), and continuity as an attitudinal contract (referring to the patient's understanding of who is in charge of their care and providing information to the patient and his or her family) (Donaldson, 1997).

3.3 conceptual framework

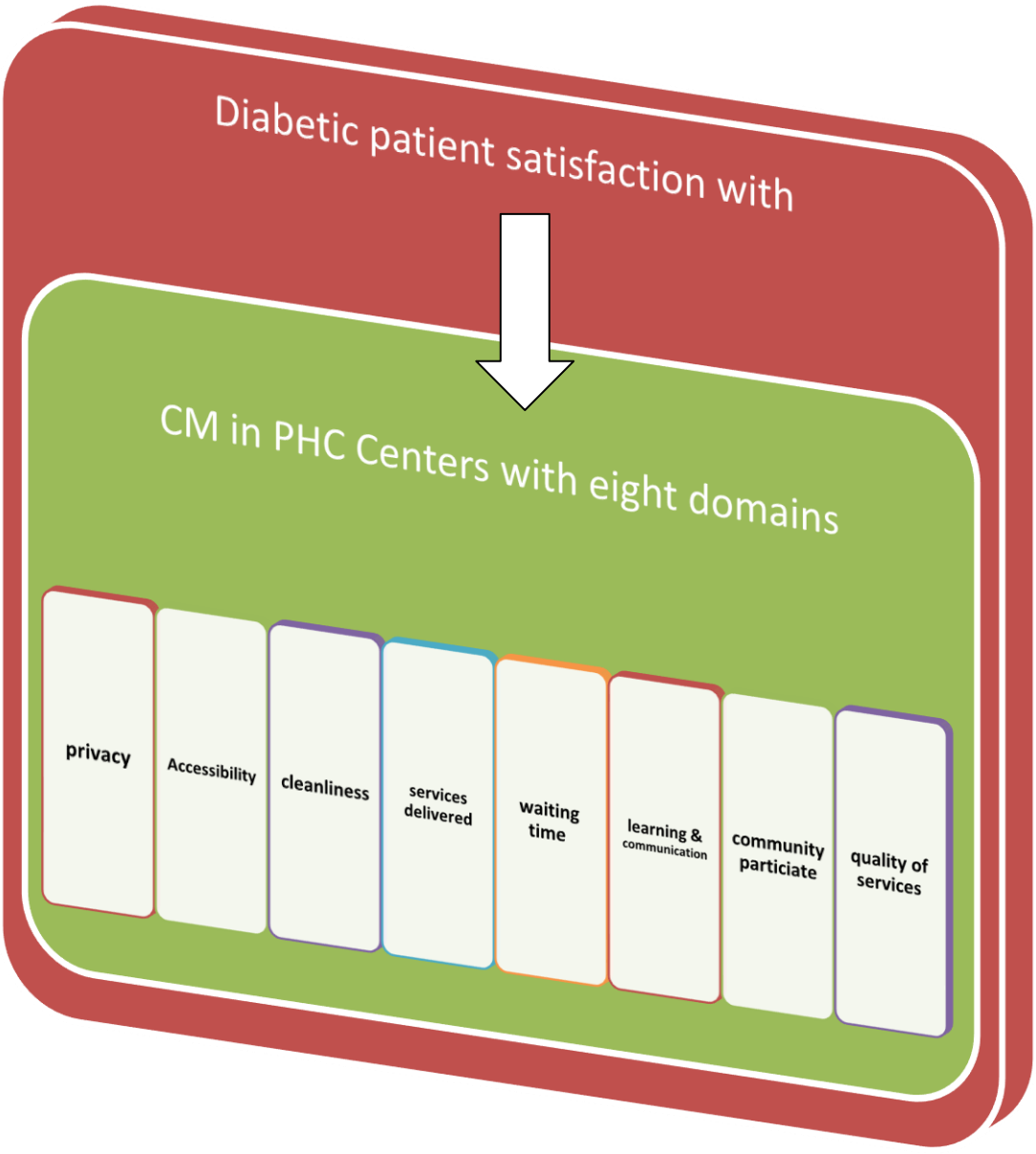

Figure (3.1): Conceptual framework

3.4 Factors affecting patient satisfaction

3.4.1 Quality of health services:

Quality in health is about care and caring. Quality of care can be defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge", it has also been defined as "the totality of features and characteristics of a service that bear on its ability to satisfy a given need" (Shaikh et al., 2008, 14).

The World Health Organization (WHO) emphasized the importance of quality in the delivery of health care, as defined by the criteria of effectiveness, cost and social acceptability. The impact of quality management and quality interventions emerged in several studies and had shown the central role of client's satisfaction as an indicator for the quality improvement (WHO 2000). Brown et al (2008) described nine quality dimensions of health service delivery: effectiveness, efficiency, technical competence, interpersonal relations, and access to service, safety, continuity and physical aspects of health care in addition to the physical environment and integration of the service (Hindi, 2002).

Modernization of health care systems and associated advances in evidence-based healthcare has raised expectations of improvements in the quality of care (Powell et al., 2003; Sheldon, 2005). Moreover, the growing demand for health care, combined with rising costs and limited resources, has increased the emphasis on the efficient use of health care resources (Campbell et al., 2000). It is predicted that chronic disease will be the leading cause of disability by 2020; unless accompanied by good management, it will also become the most expensive health care problem (DoH, 2004). The drive for accountability and associated growth in quality improvement initiatives and performance measurement has ensued. Chronic disease management is now an essential component of quality improvement efforts within health care (Davis and Wagner, 2000). The provision of clinically effective, evidence-based health care, which is both acceptable and beneficial to patients, are important elements in understanding quality in health care (Jenkinson et al., 2002; Fitzpatrick, 1997).

Measuring and communicating health care quality requires rigorous and appropriate measurement of key and consensual variables that reflect the breadth and complexity of health care. Health care quality is, by necessity, a multi-factorial and broad ranging concept; the identification and appropriate measurement of key dimensions

of health care service delivery of relevance to chronic disease management is a prerequisite to improving quality in health care (Hibbard et al., 2005). However, discrepant views between different stakeholders within the health care system, ranging from patients to providers, exist with regards to the definition and prioritization of quality issues (Campbell et al., 2002; Leatherman and Sutherland, 2003).

3.4.2 Learning and communication (interpersonal skills):

As per the Oxford English Dictionary, the word communication comes from the Latin "communicare" which means mutual interchange and "communico" means to share.

Communication is the interactive process between two people whereby one person is able to express what he/she means in a clear and unambiguous way and the other person is able to understand the meaning of the message fully and properly. In other words, one person expresses and the other understands. The responsibility for communication lies with both people – the one expressing must express as clearly as he or she possibly can and the other person must either understand or let the person who is expressing know he or she doesn't understand.

Communication is central to understanding human behavior. It is also specifically an important component in shaping human behavior to adapt and accept different health conditions. It also fortifies the relationship between doctors and patients effective communication in medical treatment leads to improved health, functional and emotional status, compliance with medical treatment, clinician satisfaction, and reduced medical malpractice risk (Wong and Lee, 2006). It is also believed to be essential for exchanging information so that both parties understand each other and the nature of the situation, develop a therapeutic relationship which fosters mutual honesty and trust, and make treatment decisions that are in the best interest of and acceptable to the patient (Allen et al., 2001).

Doctor's medical competence and his/her ability to balance between the patient's perceived needs and expectations are strongly connected to patient satisfaction.

Physicians' informativeness, interpersonal sensitivity, and (to a lesser degree) partnership-building are the main concern by patients where physician's informativeness reveled stronger patient satisfaction (Street, 1991). Although system aspects such as cost(s), access, availability and waiting times are also related to

patient satisfaction, they have always been identified as being less important than the doctor patient interaction (William and Calnan, 1991).

Effective interpersonal communication between health care provider and patient is one of the most important elements for improving patient satisfaction, compliance and health outcomes. Patients who understand the nature of their illness and its treatment, and who believe the provider is concerned about their well-being, show greater satisfaction with the care received and are more likely to comply with treatment regimes (Juzoor, 2009)

Despite widespread acknowledgement of the importance of interpersonal communication, the subject is not always emphasized in medical training. Over the past 30 years, substantial investments have been made to enhance access to basic health services in developing countries. However, there have been relatively few studies that investigate the quality of the services delivered, and fewer still that study the quality of interpersonal communication. The quality of care research that has been done shows that health counseling and provider-client communication are consistently weak across countries, regions and health services (Bérengère et al., 2007).

Even when providers know what messages to communicate, they do not have the interpersonal skills to communicate them most effectively. They often do not know how to communicate with their patients. Despite widespread acknowledgement of the critical importance of face-to-face communication between patient and provider, there are few rigorous studies of health communication in developing countries (Bérengère et al., 2007).

Serving to inform; providing or disclosing information; instructive, giving information in relation to care or services provided to the patient, it means the communication and interaction between healthcare professionals and clients and considered a priority in the quality of health care provided (http://www.knowledgetransfer.net).

In a three year analysis survey of patients satisfaction carried out in Germany, Sweden, Switzerland, the United Kingdom and United states, it was found that patient satisfaction surveys could assist in local quality improvement efforts and facilitate the identification of poor quality care for further investigation and interventions among others. It was clear from the survey that in all the five countries surveyed; patients were commonly concerned (or dissatisfied) with information and education,

coordination of care, respect for patients' preferences, emotional support, physical comfort, involvement of family and friends, and continuity and transition of care (Fitzpatrick, 2002). Participants were asked the following to assess their satisfaction level: The information given from the reception desk was clear, services provided by the center was clear, welcoming from the staff, the staff introduce themselves, staff feeling and attendance about the importance of their health problem, clear preventive instructions were given, availability of sings to the center and inside the center.

3.4.3 Waiting time:

Review of the literature indicates that's waiting time is considered a main factor in determining the level of satisfaction among clients of different health services (Mahfouz et al., 2007).

Several studies have identified prolonged waiting times as the main component of patient dissatisfaction, as well as the most frequent reason patients leave before medical evaluation(Hindi, 2002) . Many of these patients are seriously ill. Mohsin et al (2005) addressed the association between selected socioeconomic characteristics of Australian emergency patients with waiting times. Goodacre and Webster from the United Kingdom concluded that the time of presentation was the most powerful predictor of the waiting time to see a doctor (Hindi, 2002).

In 2008, a study conducted in Nablus, Palestine with the objectives were to measure patients satisfaction with services provided by hospitals at Nablus city, patients who were waiting long time (more than one hour), were less satisfied than the others, while obstetric patients were found to be the most satisfied (Al-Sharif, 2008).

In 2003, the Eastern Mediterranean published a research study done at Egypt; the study compares patient satisfaction with primary health care services and identifies factors associated with patient satisfaction in two health districts in Egypt where a project for upgrading primary health care services had been running for 3 years. Patient satisfaction was high for accessibility, waiting area conditions and performance of doctors and nurses (Mahfouz et al., 2007). However, these studies were done in areas where there were large integrated health care systems already established, unlike in Palestine where patients do not necessarily have an identifiable primary care provider. Additionally, the Palestinian population has unique cultural and linguistic features that are not present in other studies.

Reducing waiting time was the greatest issue required to be improved upon the respondent's recommendations resulting from all reviewed studies such as a study on patient's satisfaction at health centers in West India by Singh, Mustapha et al (1996). Another study conducted by Kersnik (2000) on 2160 patients with the aim of measuring their satisfaction with health care services in Slovenia, the study shows that's the poorest rating with their satisfaction was the waiting time in the waiting room (Mahfouz et al, 2007).

In this research study, women were asked about the following questions to assess their level of satisfaction with waiting time: Waiting time in the registration area, waiting time in the waiting area of the clinic, waiting time inside the clinic and during the procedure, the overall time during receiving the service.

3.4.4 Accessibility:

Access is an important concept in health policy and health services research, yet it is one which has not been defined or employed precisely. To some authors "access" refers to entry into or use of the health care system, while to others it characterizes factors influencing entry or use. The purpose of this article is to propose a taxonomic definition of "access." Access is presented here as a general concept that summarizes a set of more specific dimensions describing the fit between the patient and the health care system. The specific dimensions are availability, accessibility, accommodation, affordability and acceptability. Using interview data on patient satisfaction, the discriminant validity of these dimensions is investigated. Results provide strong support for the view that differentiation does exist among the five areas and that the measures do relate to the phenomena with which they are identified (Penchansky, 1981).

Accessibility is the possibility of the patient obtaining the services he/she needs at a time and place where he/she needs it, in sufficient amounts, and at a reasonable cost; Geographic, Demographic and affordability (UNFPA, 2009). Accessibility can be viewed as the "ability to access" and possible benefit of some system or entity, accessibility have many dimension of which is the ability to access health services by minimizing the barriers of distance and cost as well as the usability of the interface. In many countries this has led to initiatives, laws and regulations that aim toward providing universal access to the health systems at reasonable cost to citizens (UNFPA, 2009).

Other barriers to accessing services were stated by literature: Socio-demographic factors, race/ethnicity factors, knowledge, and beliefs factors (understanding and acceptance of mental health problem, individual beliefs about help-seeking, knowledge of services, fears about losing custody, stigma), 'Life circumstance' factors (conflicting demands on parents, the presence of other stresses or difficulties), mental health factors and other factors. In addition good access to health services ensures better utilization of the service and enhances the desired health outcomes (Bryony et al., 2008).

In November 2005, a random sample of Estonian residents aged 15–74 were personally interviewed using structured questionnaires (n=1446), 29% of them reported to have a chronic illness. After the implementation of the primary health care reform in Estonia, most of chronic conditions are managed by family doctors (FD) in collaboration with specialists. Although the general population has demonstrated the increase in satisfaction with health care after the reform, it has been questioned if people with chronic diseases have been left on a more disadvantaged position in the new system with some restrictions in the access to specialists. The people with chronic conditions were less satisfied with the access to the health services. They were more satisfied with their family doctors, but less with the health insurance system and they often reported their problems in seeing the specialist. Compared to other respondents, the people with chronic conditions visited their FDs and specialists more often, but no significant differences were found between their waiting times to see the FD or a specialist (Salguero et al., 2005).

Another study held in Kenya to compare the impact of socioeconomic deprivation on risky sexual outcomes in rural and urban Kenya. Quantitative data are drawn from the Demographic & Health Surveys (DHS) and qualitative data from the Sexual Networking and Associated Reproductive and Social Health Concerns study. Using two separate indicators of deprivation it has been reported that, although poverty is significantly associated with the examined sexual outcomes in all settings, the urban poor are significantly more likely than their rural counterparts to have an early sexual debut and a greater incidence of multiple sexual partnerships. The disadvantage of the urban poor is accentuated for married women; those in Nairobi's slums are at least three times as likely to have multiple sexual partners as their rural counterparts (Dodoo, 2007).

A research study was done in Egypt in 2003; the study compares patient satisfaction with primary health care services and identifies factors associated with patient satisfaction in two health districts in Egypt where a project for upgrading primary health care services had been running for 3 years. Patient satisfaction was high for accessibility, waiting area conditions and performance of doctors and nurses (Gadallah et al., 2003).

The most suitable related questions chosen from literature to ask participants about were: Availability of the service in the area of residency, reaching the service point, the time needed to reach the service point, cost of transportation, safety for them to reach the service point.

3.4.5 Service Privacy:

The term "privacy" bears many meanings depending on the context of use. Common meanings include being able to control release of information about one's self to others and being free from intrusion or disturbance in one's personal life. To receive healthcare, one must reveal information that is very personal and often sensitive. We control the privacy of our healthcare information by what we reveal to our physicians and others in the healthcare delivery system. Once we share personal information with our caregivers, we no longer have control over its privacy. In this sense, the term "privacy" overlaps with "confidentiality" or the requirement to protect information received from patients from unauthorized access and disclosure. For example, the HIPAA Privacy Standard (Department of Health and Human Services, 2002) requires healthcare providers, health plans and health plan clearinghouses to establish appropriate administrative, technical, and physical safeguards to protect the use and disclosure of individually identifiable health information. HIPAA draws on ethical standards long developed in the health care disciplines that identify protecting the confidentiality of patient information as a core component of the doctor-patient relationship and central to protecting patient autonomy. Thus, ethics, laws and regulations provide patients with certain rights and impose obligations on the healthcare industry that should keep patient health information from being disclosed to those who are not authorized to see it.

Privacy can be divided into the following separate but related concepts: Information privacy, which involves the establishment of rules governing the collection and handling of personal data such as credit information, and medical and government records. It is also known as "data protection"; bodily privacy, which concerns the protection of people's physical selves against invasive procedures such as genetic tests, drug testing and cavity searches; privacy of communications, which covers the security and privacy of mail, telephones, e-mail and other forms of communication; and territorial privacy, which concerns the setting of limits on intrusion into the domestic and other environments such as the workplace or public space. This includes searches, video surveillance and ID checks. Confidentiality between a doctor and patient means that a doctor has the express or implied duty not to disclose information received from the patient to anyone not directly involved with the patient's care. Confidentiality is important so that healthcare providers have knowledge of all facts, regardless of how personal or embarrassing, that might have a bearing on a patient's health. Patients must feel that it is safe to communicate such information freely. Although this theory drives doctor-patient confidentiality, the reality is that many people have routine and legitimate access to a patient's records (Cedric, 2003).

In 2003, the Eastern Mediterranean published a research study done at Egypt; the study compares patient satisfaction with primary health care services and identifies factors associated with patient satisfaction in two health districts in Egypt where a project for upgrading primary health care services had been running for 3 years. Patient satisfaction was high for accessibility, waiting area conditions and performance of doctors and nurses. Additionally, level of privacy in the consultation room was described as unsatisfactory by 33% of patients (Gadallah et al., 2003).

In a study done at a health centre in Malawi looking at quality of care and its effects on utilization of maternity services at a primary level, a high degree of satisfaction was noted among patients with providers' attitude (97%), technical competence (86%), and working hours (91%). However, they expressed dissatisfaction with lack of privacy (Lule et al., 2000). Confidentiality between a doctor and patient means that a doctor has the express or implied duty not to disclose information received from the patient to anyone not directly involved with the patient's care. Confidentiality is important so that healthcare providers have knowledge of all facts, regardless of how

personal or embarrassing, that might have a bearing on a patient's health. Patients must feel that it is safe to communicate such information freely. Although this theory drives doctor-patient confidentiality, the reality is that many people have routine and legitimate access to a patient's records (Bérengère, 2007). In this research study females expressed their level of satisfaction with privacy in relation to the following items; caring of privacy from the staff were clear, privacy tools are available in the examining room, the door of the exam room was closed, clean tools on couch and confidentiality of information.

3.4.6 Community participation:

The community development approach emphasizes self-help, the democratic process, and local leadership in community revitalization (Barker, 1991). Most community development work involves the participation of the communities or beneficiaries involved (Smith, 1998). Thus, community participation is an important component of community development and reflects a grassroots or bottom-up approach to problem solving. In social work, community participation refers to ". . . the active voluntary engagement of individuals and groups to change problematic conditions and to influence policies and programs that affect the quality of their lives or the lives of others" (Gamble and Weil, 1995).

One of the major aims of community development is to encourage participation of the community as a whole. Indeed, community development has been defined as a social process resulting from citizen participation (UN, 1963; Vaughan, 1972; Darby and Morris, 1975; Christenson and Robinson, 1980; Rahman, 1990; Smith, 1998). Through citizen participation, a broad cross-section of the community is encouraged to identify and articulate their own goals, design their own methods of change, and pool their resources in the problem-solving process (Harrison, 1995).

It is widely recognized that participation in government schemes often means no more than using the service offered or providing inputs to support the project (Smith, 1998). This is contrasted with stronger forms of participation, involving control over decisions, priorities, plans, and implementation; or the spontaneous, induced, or assisted formation of groups to achieve collective goals (Arnstein, 1969; Cohen and Uphoff, 1980; Rifkin, 1990; WHO, 1991; Rahman, 1993; Smith, 1998).

All stakeholders have acknowledged the role of civil society organizations in supplementing the efforts of local governments to facilitate and mobilize

communities for their full participation in local governance and the development process. Local governments with a high presence of civil society organizations have registered increased awareness of the people about their roles and relation to their respective local governments and they are able to participate more fully in the planning process (Rob Dinger, 2000).

In order to ensure increased participation of the people in planning and control of decision-making, civil society organizations together with their respective local governments, they need to be equipped with the requisite skills to mobilize and involve communities in the planning, implementation and monitoring of programs in their respective areas. This is informed by the overall policy and legal framework. Decentralization is one of the key policies. The Ministry of Gender, Labour and Social Development has developed a sector strategic plan with one of the key components being Community Empowerment. The material in this handbook is expected to be used for reference by participants and to supplement the notes and ideas generated from group discussions (Rob Dinger, 2000).

Information should be availed to all stakeholders and where possible workshops or meetings for consultation should be held with the stakeholders. They are critical at all stages of the evaluation: in the design of the terms of reference, in determining the methodology to be used, in the analysis of the data and in proposing suggestions for the future. Those who are central to project design and participatory evaluations are the stakeholders themselves.

It is important to note that participatory approaches are more labor-intensive than traditional project design or formal evaluation exercises. Sufficient time and resources should be prepared and made available for defining the terms of reference, collecting and analyzing the data, organizing workshops with staff and the communities and preparing the report. In order for participatory monitoring and evaluation to yield the needed results the design of the project or programme should also be participatory (Rob Dinger, 2000).

3.4.7 Services delivered:

The World Health Organization (WHO) defines *service delivery* as the way inputs are combined to allow the delivery of a series of interventions or health actions (WHO 2001). As noted in the *World Health Report 2000*, "the service provision function [of

the health system] is the most familiar; the entire health system is often identified with just service delivery." The report states that service provision, or service delivery is the chief function the health system needs to perform (WHO 2000).

Patients, in general, receive various services of medical care and judge the quality of services delivered to them (Choi et al., 2004). The service quality has two dimensions (a) a technical dimension i.e., the core service provided and (b) a process/functional dimension i.e., how the service is provided (Grönroos, 2000). Parasuraman et al (1988) suggested a widely used model known as SERVQUAL for evaluating the superiority of the service quality. In the SERVQUAL model, Parasuraman et al, identified the gap between the perception and expectation of consumers on the basis of five attributes viz. reliability, responsiveness, assurance, empathy and tangibles to measure consumer satisfaction in the light of service quality (Parasuraman and Berry, 1988).

In general, patient satisfaction surveys are used to examine the quality of the healthcare service provided (Lin and Kelly 1995). Much evidence has been documented for the service quality to satisfaction link in different consumer satisfaction studies including those in the area of health care marketing (Brady and Robertson 2001; Gotlieb, Grewal, and Brown 1994; Rust and Oliver 1994; Andaleeb 2001).

Health service delivery can be represented in a system's perspective, with inputs, processes, outputs, and outcomes. Some of the core inputs that are deemed necessary for health care delivery are financial resources, competent health care staff, adequate physical facilities and equipment, essential medicines and supplies, current clinical guidelines and optional policies. These inputs must be available and accessible to have an impact. They also must be used to properly carry out the system processes to produce desired health outcomes.

Service delivery access refers to the ability of a population to reach appropriate health services. (In this assessment, the WHO-defined concepts of accessibility, coverage, and acceptability coverage have been combined.) Various factors can reduce access, including presence of geographical and transportation barriers, lack of financial resources, or lack of cultural appropriateness. *Effective coverage* refers to the proportion of the population in need of an effective intervention that actually received the intervention. The *utilization rate* refers to the number of times per year the population uses health services. The utilization of health services represents

effective access to health care assumed to be the result of the interaction between supply and demand factors (Acuña, 2001).

There are various indicators of utilization; among the most common are the number of outpatient visits per person per year and the number of hospital admissions per 100 persons per year, coverage of prenatal care, coverage of professional childbirth delivery, and coverage of immunizations (Acuña, 2001).

3.4.8 Cleanliness:

Cleaning of healthcare facilities is performed for medical and cultural reasons. Maintaining an environment with a low pathogenic burden is essential for avoiding complications during the care and recuperation of patients. A healthy, safe, and aesthetically pleasing space with clean surfaces is comforting to patients and their families by giving an impression of good quality care without additional health hazards. **Pia et al(2009)**

While cleaning is important in all economic sectors, it serves the healthcare industry the dual functions of: (i) surface cleanliness, and (ii) infection prevention and control. As such, healthcare settings require intensive and frequent cleaning with a wide range of products. This document summarizes the main health and the environmental impact related to conventional surface cleaning, describes a systems approach for designing and implementing healthier and environmentally friendlier cleaning strategies for the healthcare sector, and indicates areas where future research and policy initiatives are needed. **Pia et al(2009)**

3.5 Summary

This chapter has presented the conceptual framework which consisted of eight concepts that were extracted through the available literature reviews. These concepts are: privacy, accessibility, cleanliness, services delivered, waiting time, learning and communication, community participate and quality of service.

Chapter Four: Study Methodology

4.1 Introduction

The study utilized descriptive correlation research methodology to examine the possible impact of community mobilization implemented by MoH in Nablus district with support from USAID compared with similar governmental services in comparable communities that were not exposed by the community mobilization strategies.

In this chapter, research methodology was presented. The study population and sample size, design, tools and equipment, period, response rate, piloting and the sampling method were all described. Moreover, it illustrates validity and reliability of the instrument that was constructed and used for the purpose of data collection. Data analysis procedures and ethical matters were also included in this study for the quantitative method.

4.2 Study design

This study was quantitative in nature; utilized a descriptive correlation cross sectional design. According to Polit, Beck & Hungler (2001), the main objective of descriptive research is the accurate description of persons, situations, groups and the frequency with which certain phenomena or characteristics occur. Grove & Burns (1997) had defined the quantitative research as "descriptive designs provide information about a phenomenon." Polit & Beck (2006) mentioned that the quantitative research is a collection and analysis of numeric information that typically conducted within the traditional scientific method.

4.3 Study tools

The questionnaire (Annexes 1,2,3,4) was designed by adopting using (69) points from the Patient Satisfaction Questionnaire PSQ-III. The National Center for Health Services Research (NCHSR) provided the foundation for PSQ-III. The Patient Satisfaction Questionnaire developed by Ware, Snyder, and Wright (1976) provided the foundation for PSQ-III , the NCHSR project was carried out between 1972 and 1976 at the Southern Illinois University School of Medicine. Fifty (50) items in

PSQ-III are used to score eight multi-item subscales: privacy, quality of services, cleanliness, accessibility, learning and communication, services delivered, time spent with provider, and community participation rate for continuity of care in type 2 diabetes (NCCSDO) 2006).The questionnaire was translated to Arabic, and then modified after pilot testing on twenty patients. The most popular of the questionnaire dimensions were constructed using a Likert-type 5 point scale questionnaire. According to Polit and Beck (2006), a Likert scale consists of several items that express a point of view on topic to indicate the respondent agree or disagree with each statement. A Likert scale was weighed as strongly agree=5, agree=4, neutral=3, disagree=2 and strongly disagree=1. In this study, it was used to express the attitudes of the diabetic patients with the aim to cover the most important areas of interest regarding the patient satisfaction relative to community mobilization in the study questionnaire. Quinn (2000), described the questionnaire as "a sequence of questions that the respondent is required to answer "Billings and Halstead (2005) defined the questionnaire as a method in which a person answers questions in writing on a form that is usually self-administered. Structured instruments consist of a set of questions (items) in which the wording of both the questions and response alternatives is predetermined (Polit and Beck 2006).

The questionnaire was filled by direct face to face structured interviews, and in order to maintain complete confidentiality no names were recorded on the questionnaire. Berry (1999), identified interviewing as a type of interview which researchers use to elicit information for achieving a comprehensive considerate of the interviewee's point of view or situation; it can also be used to investigate motivating areas for supplementary analysis. This type of interview involves questioning wherever essential to obtain data deemed functional by the researcher. Interviews are a more personal form of surveys than questionnaires. Interviews can occur on an individual basis or within groups and either over the telephone or in person. Properly conducted interviews can provide managers and decision makers with a deeper understanding of patient perceptions about their hospital environment (Grimes, 2003).The advantage of interviews is their personal form, the interviewer has the opportunity to probe or ask follow-up questions, allows interviewer the opportunity to correct misunderstandings, provides for a wide variety of views and high levels of flexibility and interviews are generally easier for the respondent, especially if what is sought is opinions or impressions (Grimes, 2003).

Disadvantages of the personal interviews are that time consuming for both parties involved, skilled interviewer is required, costly, interviewer bias can influence and must be conducted in conducive environment (Grimes, 2003).

4.4 Study variables

Face to face interview questionnaire consisted of independent and dependent variables as follows:

1. Independent variables: are the characteristics of the respondents which included:

- Age
- Gender
- Marital status
- Educational level
- Income
- Health insurance
- Center name
- Health status
- Center choice
- Diabetic history
- Number of visits
- Beginning of treatment

2. Dependent variables: This included the following:

- Quality of services: (1-13).
- Cleanliness: (14-18).
- Waiting time: (19-24).
- Services delivered: (25-33).
- Privacy: (34-37).
- Accessibility: (38-46).
- Learning and communication: (47-60).
- Community participation rate: (61-69).

4.5 Sampling methodology

4.5.1 Study population:

Polit and Beck (2006) described the population as "the entire group of persons or subjects that is of interest to the researcher. A total of 152 diabetic patients were interviewed. Sample size was calculated with a margin of error of 5%, and a confidence level of 95%. The total diabetic patients in the four central clinics that deliver diabetic services are: Huwwara 38 diabetic patients, Asira 38 diabetic patients, Beta 38 diabetic patients and Qabalan 38 diabetic patients.

The sample size was calculated by using the sample size calculator. (*http://www.macorr.com/sscalculator.htm).*

4.5.2 Sampling procedures:

The results of this survey based upon information obtained from a randomly drawn sample of four clinics in Nablus villages. Patients in our study were chosen randomly form the following centers:

1. Huwwara clinic.
2. Asira clinic
3. Beta clinic.
4. Qabalan clinic

The sample selection process consisted of employing the methods of probability by proportionate sampling.

4.5.3 Sample Frame:

List of patients who are registered to diabetic clinics .

4.6 Inclusion criteria

- Those who consented to participate.
- Patients over the age of 20 years, and,
- Patients who were registered to diabetic clinic.

4.7 Exclusion criteria

The following exclusion criteria were used to screen the sample population:

- Those who did not consent to participate.
- Patients under 20 years, and
- Non diabetic patients.

4.8 Piloting of the study tool

The questionnaire was piloted before using in the field. Ten (10) diabetic patients in Huwwara clinic and ten (10) diabetic patients in Beta clinic were asked to fill in the questionnaire interview to examine the clarity, validity and comprehensiveness of the instrument. The data gathered from piloting were not included in the main study. The feedback received on the pilot was used to finalize the presentation and wording of the questionnaire interview and to clarify any unclear question.

4.9 Validity of the study tool

After developing the questionnaire interview, it was sent to a team of (6) experts (Annex 5) in this field who have expertise in research to determine whether the items in the questionnaire were relevant and suitable to study purpose. The questionnaire was modified slightly according to experts' suggestions. The researcher responded to the views of the experts and carried out what is necessary to be edited and to be deleted in the light of their suggestions after registration in a form that was prepared for this purpose. According to Polit and Hungler (2001), validity refers to "the degree to which the instrument measures what is supposed to measure".

4.10 Reliability of the study tool

Reliability of the instrument was tested using internal reliability of Cronbach's Alpha. The questionnaire as a total score, showed an excellent coefficient (α=0.89) for 69 items, and virtually good coefficients for all domains (quality of services, cleanliness, waiting time, services deliver, privacy, accessibility, learning and communication and community participate) were 0.929 ,0.818, 0.872, 0.736 ,0.781, 0.895, 0.890, 0.986.

Table (4.1): Data collection instrument reliability.

No:	Field	No. of items	Reliability coefficient
1	Quality of services	13	0.929
2	Cleanliness	5	0.818
3	Waiting time	6	0.872
4	Services delivered	9	0.736
5	Privacy	4	0.781
6	Accessibility	9	0.895
7	Learning and communication	14	0.890
8	Community participate	9	0.986
9	Total	69	0.89

Polit and Beck (2006) defined the reliability of a quantitative instrument as "a major criterion for assessing its quality and adequacy. Instrument reliability is the consistency with which it measures the target attribute ". Reliability also concerns a measure's accuracy. A reliable measure maximizes the true score component and minimizes the error component (Polit and Beck, 2006).

4.11Ethical consideration

4.11.1 **Formal letter**:

The study proposal was approved by the scientific research committee of the Public Health Department as well as the faculty of graduate studies scientific research board at Al-Quds University. Before beginning the study, letters were sent from Al-Quds University to MoH (director of primary health care) and USAID-Flagship who are responsible of the project, (Annex 6) in which the study purpose was explained. An official Flagship permission had been asked for the researcher to visit the clinics, to make questionnaire interviews and to facilitate data collection procedures. The researcher had visited the targeted clinics before beginning of the study in order to get to know the place and to explain the research purpose.

4.11.2 Informed consent:

An informed consent was attached to the questionnaire. Participants were given full explanations about the research, including the purpose, nature of the study and importance of participation. In addition, the participants were assured confidentiality of information and voluntary participation, and were given total freedom to accept or reject participation in this research (Annex 7).

4.12 Data analysis

Data were entered and analyzed by using [(SPSS version 13) Statistical Package for the Social Sciences]. Descriptive statistics including frequencies, means, percentages and standard deviations were computed for continuous numeric variables. An independent t-test and one-way ANOVA statistical test were used to test the study questions. The relation between the items in the questionnaire and study variables was established.

Polit and Beck (2006) defined Analysis of Variance (ANOVA) as "a statistical procedure for testing mean differences among three or more groups by comparing variability between groups to variability within groups". Also, they defined t-test as "a parametric statistical test for analyzing the difference between means in four clinics.

All questions were asked in Arabic. Criteria used by interviewer for accepting a response to each of the questions included:

- Clarity of response.
- Specificity of response.
- Relevance of response.

4.13 Period of the Study

This study was conducted within the period December 2011- and October 2012.

4.14 Summary

This chapter offered a synopsis to the study design, study tool, study variables and operational definition of the concepts, sampling methodology, piloting, validity and reliability of the study tool, data collection, data analysis besides to ethical consideration and statistical analyses used in this study and period of the study.

Chapter Five: Analysis and Results

5.1 Introduction

The first section of this chapter presents a demographic description of the sample in term of type of clinics, center name, age, gender, marital status, level of education, monthly income, number of visits, health insurance, center choice, other diseases rather than diabetes, knowledge about centers, since of disease and beginning of treatment. The second section includes the level of patient satisfaction with clinic services in relation to dependent variables. The third section includes results of hypotheses and description of the statistical significance and insignificance between dependent and independent variables.

5.2 Socio-demographic characteristics of the respondents

Table (5.1): Distribution of study sample according to the socio-demographic factors.

No:	Variable	Category	Frequency	Percent
1	**Name of clinic**	Huwwara	38	25
		Asira	38	25
		Beta	38	25
		Qabalan	38	25
2	**Age**	20-29	10	6.6
		30-39	10	6.6
		40-49	33	21.7
		50-59	54	35.5
		60 years / >	45	29.6
3	**Gender**	Male	63	41.4
		Female	89	58.6
4	**Marital status**	Single	16	10.5
		Married	118	77.6
		Divorced	1	0.7
		Widowed	17	11.2
5	**Level of education**	Illiterate	28	18.4
		Primary school	31	20.4
		Secondary school	32	21.1
		High school(Tawjihi)	41	27
		Diploma	8	5.3
		Baccalaureate and more	12	7.9
6	**Monthly net income**	200 JDs and less	65	42.8
		201-400 JDs	64	42.1
		401-600 JDs	19	12.5
		Over 600 JDs	4	2.6

Name of the clinic: We notice from table (5.1) that 25% of cases were from Huwwara, 25% of cases were from Asira, 25% of cases were from Beta and 25% of cases were from Qabalan, each center of them encompasses 38 cases.

Age: Table (5.1) shows that 35.5% of the participants are aged between 50–59 years, whereas 29.6% aged between 60 years or more, 21.7% were between 40–49 years, while the lowest percentages were 6.6% aged between 20–29 and 30-39 years.

Gender: It is noted that 41.4% of the respondents were males and 58.6% were females.

Marital status: 77.6% were married, 10.5% were singles, widowed were 11.2% and those who were divorced were 0.7%.

Level of education: It is determined that the level of education of the cases for the secondary school was 21.1%, primary school was 20.4%, illiterate was 18.4%, diploma was 5.3% and baccalaureate and above was 7.4%.

Monthly net income: It is shown that 42.8 % of cases their monthly income were up to 200 JDs, 42.1% were from 201–400 JDs, 12.5% were from 401–600 JDs and 2.6% were over 601 JDs.

Table (5.2): Distribution of study sample according to patient history.

7	**Number of visits**	First Second Third > 3	5 9 16 122	3.3 5.9 10.5 80.3
8	**Reason for choosing center**	Proximity Special services Center reputation Specialist in center Other	56 9 4 75 8	36.8 5.9 2.6 49.3 5.3
9	**Source of knowledge**	Friends Neighbor Council Newspaper Other	27 9 37 1 78	17.8 5.9 24.3 0.7 51.3
10	**Health insurance**	Governmental Private None	145 6 1	95.4 3.9 0.7
11	**History of diabetes**	Positive Negative	109 43	71.7 28.3
12	**Diseases rather than diabetes**	Hypertension Heart Kidney Hypertension and heart Other	46 9 21 9 67	30.3 5.9 13.8 5.9 44.1
13	**Beginning of diabetes treatment**	Direct Late	112 40	73.7 26.3

14	**Disease duration**	6 months and less > 6 months to 1 year > 1 year	4 15 133	2.6 9.9 87.5

Table 5.2 summarizes the distribution of patients according to their history:

Number of visits/month: It is demonstrated from table (5.2) that 80.3% of participants had visited the clinics more than three times in the month, 10.5% had their third visit, 5.9% had visited the clinics for two times while the lowest percentage 3.3% was their first visit.

Reason for choosing the center: Table (5.2) illustrates that 49.3% of participants choose the health center because of the availability of a specialist in the center, 36.8% of participants choose the center because of its proximity to the place of their residence, 5.9% for the special services it has while the lowest percentage 2.6% choose center for its reputation.

source of knowledge: 51.3% of participants knew about the center from other source, 24.3% of participants knew from local council, 17.8% from friends and 5.9% of participants from neighbors while the lowest percentage 0.7% knew about the center from newspapers.

Insurance type: We notice that the majority of the respondents (95.4%) having government health insurance, 3.9% have private insurance and 0.7% are not insured.

History of diabetes: It is noted from the table (5.2) that majority of study sample are positive with diabetes 71.7% and 38.3% of cases don't have diabetes.

Types of other diseases rather than diabetes: Table (5.2) shows that 44.1% of the participants were having other disease, 30.3% have hypertension, 13.8% were have kidney disease, while the lowest ratio 5.9% for those patient who have heart disease and patient have both hypertension and heart disease.

Beginning of treatment diabetic treatment: We notice that majority of respondents had direct with treatment 73.7% and 26.3% of cases had late treatment.

Disease duration: According to table (5.2), the majority (87.5%) are having diabetes for more than one year, 9.9% from 6-12 months and 2.6% have diabetes less than six months.

5.3 Analysis of the factors influencing patient satisfaction during implementing C.M.

To explain the results, the researcher calculated the means at the fields' level to the tool as a whole and to the statements level in each field. The researcher determined the level degree of patient satisfaction as shown in table (5.3). It was specified that the length of cells was determined through the Likert-type-five- scale (Lower and upper limits) (Madi, 2010).

Table: (5.3): Likert-type-five-scale approval.

No:	Cell length	Degree of agreement	Percentage (%)
1	1-2.60	Low	20-52
2	2.61-3.50	Moderate	More than 52-68
3	3.51-5	High	More than 68-100

Table (5.4): Means and S.Ds of quality of service provided for all participants:

No:	Statement	Mean	S.D.
12	You were tested for diabetes before seeing the physician	4.09	0.800
7	Staff provided assistance whenever possible.	4.08	0.762
5	You felt you were warmly welcome generally by staff.	4.06	0.794
11	Medical instructions about the prescription were understandable.	4.05	0.730
10	You felt that staff was kind with you.	4.01	0.853
8	You trust this center because it has a good reputation through providing health services.	4.00	0.745
3	You had the treatment / prescription.	3.98	0.833
13	Health services you came for are presented within center	3.98	0.876
6	You felt you were interested by staff all stages of being serviced in the clinic.	3.97	0.813
9	You feel comfort because the doctors and health workers are qualified and have experience in providing this service	3.95	0.856
4	It was clear that doctor was very interested in your health problem.	3.92	0.857
1	Overall services were perfect as originally expected.	3.80	0.935
2	Health problem you came for is treated or within treatment.	3.76	0.896
	Quality Of Services	3.92	0.765

The results of this dimension (Quality of service) show the following (see table 5.4):

The total mean of this dimension was (3.92) shows that there was a high degree of agreement among the participants on all paragraphs. The range of means was (3.76–4.09) which indicates a homogenous readings and responses from the participants; where all means are close to each other indicating to high degree of agreement among the participants about the quality of service provided. The results show that the "You were tested for diabetes before seeing the physician" had the highest score with a mean of (4.09) and 'Health problem you came for is treated or within treatment had the lowest item score with a mean of (3.76).

'The Staff provided assistance whenever possible' occupies the 2nd rank having mean (4.08) and You felt you were warmly welcome generally by staff occupies the 3rd degree among providers to indicate to the quality standards applied at those clinics by having mean (4.05).

Most participants agreed that "They felt that staff was kind with them" are true and occupies the 5th degree of ranking with a mean of (4.01) indicating to the importance of this item for providers as a quality indicator from the fifth level.

Generally, there is a notion that the total value of the quality of services was high with a mean (3.92).

Table (5.5): Means and S.D of cleanliness for all participants:

No:	Statement	Mean	SD
17	Health workers use specific clean tools.	3.98	0.750
14	Physician's office was clean.	3.97	0.796
18	Bed sheets were clean.	3.93	0.750
16	Waiting area for the reviewers was clean.	3.69	1.004
15	Circumscription of center was clear.	3.47	1.201
	Cleanliness total	3.80	0.909

The results of this domain (cleanliness) show the following (see table 5.5):

The total mean of this dimension was (3.80) shows that there was a high degree of agreement among the participants on all paragraphs. The range of means was (3.47–3.98) which indicates a homogenous readings and responses from the participants; where all means are close to each other indicating to high degree of agreement among the participants about the cleaning and surrounded centers. The results shows that the "Health workers use specific clean tools" had the highest score with a mean of 3.98

while ‘Circumscription of center was clear “had the lowest items score with a mean of 3.47.

“The Physician’s office was clean” occupies the 2nd degree having mean (3.97) and ‘Bed sheets were clean” occupies the 3rd degree among providers to indicate to the cleanliness applied at those clinics by having mean (3.93).

Most participants agreed that ‘Waiting area for the reviewers was clean’ are true and occupies the 4th degree of ranking with a mean of (3.69) indicating to the importance of this item for providers as cleanliness.

But “Circumscription of center was clear” shows a moderate degree and occupied the 5th rank.

Generally, it is noted that the total value of the quality of services was high with a mean (3.80).

Table (5.6): Means and S.D of waiting time for the participants

No:	Paragraph	Mean	S.D.
20	Registration producers were fast.	4.07	0.806
21	The engagement to take the service was timely.	3.89	0.970
19	Staff kept the waiting time to be fit.	3.76	0.993
23	The time you spent with the service provider was convenient.	3.55	1.240
24	Gross time deposited to take the whole service was fit.	3.31	1.340
22	Waiting before entering the test room was appropriate.	3.27	1.290
	Total Waiting time	3.64	1.106

Results of table (5.6) about waiting time dimension show:

The total mean of all paragraphs (3.64) indicates a high degree of agreement of this level from all participants. The means ranged between (3.27-4.07). This is considered to be close and homogenous response for waiting time items. The item “Registration producers were fast” had the highest score of agreement from all participants, while the ‘Waiting before entering the test room was appropriate’ had the lowest score. ‘Registration producers were fast.’ had the highest score of agreement in this dimension from all participants and considered to the most positive aspect of waiting time for the different providers. Its mean was (4.07) with this level agreement. ‘The engagement to take the service was timely’ ‘Staff kept the waiting time to be fit’, The time you spent with the service provider was convenient, are also considered to be positive points for all providers having the 2nd rank of waiting time paragraphs with (3.89), (3.76),(3.55) means respectively.

‘Gross time deposited to take the whole service was fit.’ had the 3rd rank with mean of (3.31) with a moderate agreement level from this grade.

The item ‘Waiting before entering the test room was appropriate.’ had the lowest score with a mean of (3.27) and a moderate agreement level, so it should not be ignored and have to be enhanced.

Table (5.7): Means and S.D of services delivered for the participants:

No	Paragraph	Mean	S.D.
26	Comprehensive test (Cumulative diabetes, Cholesterol, fat) is carried out regular	4.39	1.030
25	You are tested for diabetes before each visit	4.28	1.060
28	You are tested for weight and blood pressure each visit	4.10	1.270
27	Insulin medicine and tablets are permanently available in the center	3.76	1.380
29	When needed, you are transferred to hospital easily	3.70	1.010
30	You are being provided with medical literatures about diabetes in the center	3.40	1.280
32	You are submitted to a specialist doctor (heart, kidney, endocrine glands)	2.61	1.54
31	You are being checked for feet regularly	2.42	1.500
33	ECG is done periodically	2.22	1.41
	Total services delivered	3.46	1.330

Results of table (5.7) about services delivered domain show:

Regarding delivery of services within the clinics 9 items were examined. The total mean of all paragraphs (3.46) indicates a moderate degree of agreement of this level from all participants. The means ranged between (2.22-4.39) indicating to heterogeneous answers with different levels all were weak, moderate or high.

The item “Comprehensive test (Cumulative diabetes, Cholesterol, fat) is carried out each visit” had the highest score of agreement from all participants, while the ‘ECG is done periodically’ had the lowest score.

Table (5.7) shows that means were high to the first five statements whereas the means were between (4.39-3.70), and were in moderate degrees to the statements from “You are being provided with medical literatures about diabetes in the centers" and "You are submitted to a specialist doctor (heart, kidney, endocrine glands" and the means(3.40)(2.61) respectively, and were low to the statements “You are being checked for feet” and “ECG is done periodically” with means (2.42)(2.22) .

Table (5.8): Means and S.D of Privacy for the participants:

No:	Paragraph	Mean	S.D.
37	Generally, the team maintains the information secrecy.	3.98	0.837
34	It was notable taking care of your privacy during the test.	3.78	0.980
35	The testing room was equipped with privacy means.	3.78	0.940
36	To protect your privacy, the health worker closed the door.	3.42	1.22
	Total Privacy	3.67	0.994

Table (5.8) about privacy dimension shows:

The total average of means (3.67) shows a moderate degree of agreement which gives this dimension the 4th level of agreement. The range of means was between (3.98–3.42) indicating to a homogenous readings, responding and answers with similar levels all was moderate.

Participants indicate to this paragraph ‘‘Generally, the team maintains the information secrecy’ had the highest score with a mean (3.98). ‘It was notable taking care of your privacy during the test “‘The testing room was equipped with privacy means” are also good indicators for privacy where participants give those paragraphs a mean of (3.78) with a 2nd rank. And ‘‘To protect your privacy, the health worker closed the door” had the lowest ranking with a mean of (3.42).

Table (5.9): Means and S.D of accessibility for the participants:

No:	Statement	Mean	S.D.
43	It was safe to come to the center.	4.02	0.781
38	Accessibility to the centre was easy.	3.88	0.969
42	Cost accessibility was acceptable	3.81	0.965
39	It was safe to come to the center.	3.80	1.000
40	The center is located within reasonable range.	3.78	1.000
41	Home and away to the center due to the adequate time was reasonable.	3.74	1.05
45	When a problem happens, it is easy for the staff arrivals.	3.06	1.26
46	When in need, it is easy for the specialist arrivals	2.99	1.25
44	The existence of a parking encourages you to attend the center to take the service.	2.97	1.26
	Total Accessibility	3.56	1.201

Respondents’ answers were homogenous regarding items for accessibility to the service. The item “It was safe to come to the center’ had the highest score with a mean of (4.02) among all items related to accessibility to the center, while ‘The existence of a parking encourages you to attend the center to take the service’ had the

lowest score with a mean score of (2.97) indicating to the need for taking this item into consideration from the providers.

The total mean of all paragraphs (3.56) shows high level of agreement this grade from all participants at this dimension where the means ranged from (4.02-2.97) indicating to a moderate to high homogenous respond and readings from all participants. 'It was safe to come to the center', 'Accessibility to the centre was easy', 'Cost accessibility was acceptable', 'The center is located within reasonable range' and 'Home and away to the center due to the adequate time was reasonable' (4.02)(3.88)(3.81)(3.80)(3.78)(3.74) respectively.

The second part shows moderate level of agreement from all participants at this dimension where the mean (3.06) for "When a problem happens, it is easy for the staff arrivals' and (2.99) for' When in need, it is easy for the specialist arrivals' and 'Availability of Parking encourages you to come to this center' had the lowest ranking grade (3.83) mean indicting to the need to enhance this indicator to increase the accessibility aspects to the service centers.

Table (5.10): Means and S.D of Learning and communication for the participants

No:	Statement	Mean	S.D.
51	Communication level between patient and the staff was good.	4.15	0.716
58	Patients' trust in staff is good.	4.15	0.716
53	Staff and physicians answer all questions.	4.11	0.733
50	Communication level between the patient and physician was good.	4.10	0.756
57	Patient is being respected by staff	4.09	0.734
55	Patient-staff relationship is characterized by brotherhood and friendship.	4.09	0.832
52	Complaint of patient is being heard by the staff.	4.06	0.819
60	Receptionist explains issues quietly.	4.06	0.819
54	Staff are doing their best in order the patient feels comfort.	4.01	0.825
59	Physician gives enough time in testing and instructing the patient.	3.93	0.960
49	Were you identified to your illness and means of protection by the staff?	3.57	1.305
48	Did you have a health education inside the center (medical literature, seminars...)?	2.92	1.447
56	Physician uses some medical terms during his speech to the patient without elaboration.	2.75	1.550
47	Did you have a health education outside the center	2.59	1.483
	Total Learning and Communication	3.77	0.978

Results of this dimension (gender sensitivity) show:

The total average of means (3.77) shows a high degree of agreement for this dimension. The range of means was between (4.15–2.59) indicating to heterogeneous answers with different levels of high or moderate.

From the participants point of view; The paragraph ‘Communication level between patient and the staff was good' and 'You feel staff respect' and 'Patients’ trust in staff is good’ was ranked the first position as a good indicator for accepting the learning and communication dimension with a mean of (4.15). ‘The staff and physicians answer all questions’ are also a positive point for providers from the participants view and ranked the 2nd position with a mean of (4.11). ‘The Communication level between the patient and physician was good’ ranked the 3rd position with a mean of (4.10). 'Patient is being respected by staff' and 'Patient-staff relationship is characterized by brotherhood and friendship' with mean (4.09). 'Complaint of patient is being heard by the staff' and 'Receptionist explains issues quietly' with mean (4.66). 'Staff are doing their best in order the patient feels comfort' with mean (4.01). 'Were you identified to your illness and means of protection by the staff' with mean (3.57) .

The second part shows moderate level of agreement from all participants at this dimension where the mean (2.92) for “Did you have a health education inside the center (medical literature, seminars...)?', and (2.75) for’ Physician uses some medical terms during his speech to the patient without elaboration' and ‘Did you have a health education outside the center’ had the lowest ranking grade (2.59) mean indicting to the need to enhance this indicator to increase the learning and communication aspects to the service centers.

Table (5.11): Means and S.D of community participate for the participants:

No:	Statement	Mean	S.D.
68	Did you feel the change in the nature of services provided for the better in the clinic after the application of CM …..?	2.38	1.46
69	Did you feel a change in the treatment for the better by the medical staff after your participation in these committees	2.38	1.47
67	Did your participation in community committees contribute in raising awareness to you and other patients?	2.36	1.48
66	Did your participation in the programme contribute correctly the introduction of your illness and its preservation?	2.34	1.49
61	Did you participate in planning the posed programme since the project has begun?	2.25	1.42
62	Did you participate in the middle of the project?	2.23	1.40
64	Is an extensive discussion taken place to set priorities during evaluation process?	2.21	1.41
65	Have you been signed up to monitor and evaluate the programme?	2.20	1.38
63	Did you make an evaluation process to the programme before it has begun?	2.19	1.38
	Total Community Participate	2.28	1.43

Results of this dimension (gender sensitivity) show:

The total average of means (2.28) shows a low degree of agreement for this dimension. The range of means was between (2.38–2.19) indicating to homogeneous answers with same levels of low agreement. Participants indicate to this paragraph 'Did you feel the change in the nature of services provided for the better in the clinic after the application of CM' and 'Did you feel a change in the treatment for the better by the medical staff after your participation in these committees' had the highest score the mean was (2.38) and the lowest ranking with a mean of (2.19). "Did your participation in community committees contribute in raising awareness to you and other patients" had a mean of (2.36) with the 2nd rank. And ''Did your participation in the programme contribute correctly the introduction of your illness and its preservation" , "Did you participate in planning the posed programme since the project has begun", "Did you participate in the middle of the project" and "Is an extensive discussion taken place to set priorities during evaluation process" with means of (2.34)(2.25)(2.23)(2.21)(2.20) respectively.

5.4 Answering research questions of the study

To answer the research questions of the study, the researcher used Anova, t-test and Pearson correlation. **Research question one**: Is there a difference in quality services between clinics which received CM strategies and those clinics that did not receive CM intervention? To answer the first question, analysis was done to the responses of the respondents, and means (M) and standard deviations (SD) were calculated to the centers according to quality of services, and were as follows;

Table (5.12): Quality of services' means and standard deviation

No:	Centers name	Mean	S. Deviation
1	Huwwara	4.09	0.57
2	Asira	4.32	0.48
3	Beta	3.95	0.46
4	Qabalan	3.52	0.62

It is clear from the above table that Huwwara and Asira where CM strategies were received are the highest means were in Asira center (4.32), followed by Huwwara center (4.04) and clinics that did not receive CM intervention Beta center (3.95) and the least in Qabalan center with a mean (3.52), while the highest standard deviation (0.62) was in Qabalan and the least in Beta (0.64).

As it turns out, there are out-warded differences between the means of centers providing services, and to insure this difference is statistically significant, One Way Anova was used and the results as follow;

Table (5.13): F test for Question one

Research question one		Sum of Squares	DF	Mean Square	F	Sig.
Quality of services	Between Groups	12.886	3	4.295	14.661	0.000
	Within Groups	43.363	148	0.293		
	Total	56.249	151			

We notice that the result of F from the former table equals (14.66) which is significant (0.00) that is less than 0.05 meaning that there are differences among the centers in service quality where study has been approached which are: Huwwara, Beta, Asira and Qabalan.

To know the differences, we use LSD Post-Hoc test to the level of difference and the results are as follow:

Table (5.14): LSD Post-Hoc test for the differences according to quality of services

No:	Center	Huwwara	Asira	Beta	Qabalan
1	Huwwara	----------	- 0.23	0.135	0.56*
2	Asira		----------	0.36*	0.799*
3	Beta			----------	0.43*
4	Qabalan				----------

The results of table (5.14) show that there are statistically significant differences at $\alpha \leq 0.05$ between Huwwara and Qabalan in quality of service in favor of Huwwara, a difference between Asira and each of Qabalan and Beta in favor of Asira, also there was a difference between Beta and Qabalan in favor of Beta.

Research question two: Is there a difference in the patient participation rate in planning and designing health services between patients exposed to community mobilization strategies and patients who were not exposed to CM?

To answer the second question, analysis was done to the responses of the respondents, and means (M) and standard deviations (SD) were calculated to the centers according to community participate, and were as follows;

Table (5.15): Community participation means and standard deviations

No:	Center	Mean	S. Deviation
1	Huwwara	2.66	1.2
2	Asira	2.94	1.5
3	Beta	1.46	0.76
4	Qabalan	2.06	1.35

It is clear from the above table that Huwwara & Asira where CM strategies were received the highest means were in Asira center (2.94), followed by Huwwara center (2.66), and those clinics who did not receive CM intervention Qabalan center (2.06) and the least in Beta center with a mean (1.46), while the highest standard deviation (1.5) was in Asira and the least in Beta (0.76).

As it turns out, there are out warded differences between the means of centers providing services, and to insure this difference is statistically significant, One Way Anova was used and the results as follow;

Table (5.16): F test for the research question two

Question two		Sum of Squares	DF	Mean Square	F	Sig.
Community participate	Between Groups	49.752	3	16.584	10.60	0.000
	Within Groups	231.541	148	1.564		
	Total	281.293	151			

We notice that the result of F from the former table equals (10.6) which is significant (0.00) that is less than 0.05 meaning that there are differences among the centers in community participate where study has been approached which are: Huwwara, Beta, Asira and Qabalan. To know the differences, we used LSD Post-Hoc test to the level of difference and the results are as follow:

Table (5.17): LSD Post-Hoc test for the differences according to community participation

No:	Center	Huwwara	Asira	Beta	Qabalan
1	Huwwara	----------	- 0.26	1.21 *	0.616 *
2	Asira		----------	1.47 *	0.87*
3	Beta			----------	0.59 *
4	Qabalan				----------

The results of table (5.17) show that there are statistically significant differences at $\alpha \leq 0.05$ between Huwwara and each of Qabalan and Beta in community participate in favor of Huwwara, a difference between Asira and each of Qabalan and Beta in favor of Asira, also there was a difference between Beta and Qabalan in favor of Beta.

Research question three: Is there a difference in the patient utilization (services provided) of services between patients exposed to community mobilization strategies and patients who were not exposed to CM?

To answer the third question, analysis was done to the responses of the respondents, and means (M) and standard deviations (SD) were calculated to the centers according to services provided, and were as follows;

Table (5.18): Means and standard deviation of Services provided

No:	Center	Mean	S. Deviation
1	Huwwara	3.52	0.65
2	Asira	3.8	0.81
3	Beta	3.4	0.57
4	Qabalan	2.97	0.62

It is clear from the above table that Huwwara & Asira which received CM strategies had the highest means were in Asira center (3.8), followed by Huwwara center (3.52), and clinics that did not receive CM intervention Beta center (3.4) and the least in Qabalan center with a mean (2.97), while the highest standard deviation (0.81) was in Asira and the least in Beta (0.57).

As it turns out, there are out-warded differences between the means of centers providing services, and to insure this difference is statistically significant, One Way Anova was used and the results as follow;

Table (5.19): F test for Question three

Question three		Sum of Squares	DF	Mean Square	F	Sig.
Services provided	Between Groups	14.104	3	4.701	10.368	0.000
	Within Groups	67.109	148	0.453		
	Total	81.212	151			

We notice that the result of F the former table equals (10.368) which is significant (0.00) that is less than 0.05 meaning that there are differences among the centers in services provided where study has been approached which are: Huwwara, Beta, Asira and Qabalan.

To know the differences, we used LSD Post-Hoc test to the level of difference and the results are as follow:

Table (5.20): LSD Post-Hoc test for the differences according to services provided

No:	Center	Huwwara	Asira	Beta	Qabalan
1	Huwwara	----------	- 0.29	0.11	0.56 *
2	Asira		----------	0.4 *	0.84*
3	Beta			----------	0.43 *
4	Qabalan				----------

The results of table (5.20) show that there are statistically significant differences at $\alpha \leq 0.05$ between Huwwara and Qabalan in services provided in favor of Huwwara, a difference between Asira and each of Qabalan and Beta in favor of Asira, also there was a difference between Beta and Qabalan in favor of Beta.

Research question four: Is there a significant difference in the patient satisfaction with access to services in the target clinics exposed to community mobilization with client satisfaction with accessibility to services in other clinics not exposed to?

To answer the fourth question, analysis was done to the responses of the respondents and means (M) and standard deviations (SD) were calculated to the centers according to accessibility, and were as follows;

Table (5.21): Accessibility means and standard deviation

No:	Center	Mean	S. Deviation
1	Huwwara	3.74	0.77
2	Asira	3.95	0.96
3	Beta	3.32	0.61
4	Qabalan	3.2	0.55

It is clear from the above table that Huwwara & Asira which received CM strategies had the highest means were in Asira center (3.95), followed by Huwwara center (3.74), and clinics did not receive CM intervention Beta center (3.32) and the least in Qabalan center with a mean (3.2), while the highest standard deviation (0.96) was in Asira and the least in Qabalan (0.55).

As it turns out, there are out-warded differences between the means of centers providing services, and to insure this difference is statistically significant, One Way Anova was used and the results as follow;

Table (5.22): F test for Question four

Question four		Sum of Squares	DF	Mean Square	F	Sig.
Accessibility of services	Between Groups	13.090	3	4.363	7.872	0.000
	Within Groups	82.030	148	0.554		
	Total	95.120	151			

We notice that the result of F the former table equals (7.872) which is significant (0.00) that is less than 0.05 meaning that there are differences among the centers in services provided where study has been approached which are: Huwwara, Beta, Asira and Qabalan.

To know the differences, we use LSD Post-Hoc test to the level of difference and the results are as follow:

Table (5.23): LSD Post-Hoc test for the differences according to accessibility of services

Center	Huwwara	Asira	Beta	Qabalan
Huwwara	----------	- 0.21	0.415 *	0.502 *
Asira		----------	0.625 *	0.713 *
Beta			----------	0.087
Qabalan				----------

The results of table (5.23) show that there are statistically significant differences at $\alpha \leq 0.05$ between Huwwara and each of Qabalan and Beta in accessibility of services in favor of Huwwara, a difference between Asira and each of Qabalan and Beta in favor of Asira, also there was a difference between Beta and Qabalan in favor to Beta.

Research question five: Is there a significant difference in the satisfaction of patients with the waiting time of services received by diabetic patients in communities exposed to community mobilization?

To answer the fifth question, analysis was done to the responses of the respondents and means (M) and standard deviations (SD) were calculated to the centers according to waiting time, and were as follows;

Table (5.24) waiting time means and standard deviation

No:	Center	Mean	S. Deviation
1	**Huwwara**	3.69	1.01
2	**Asira**	4.27	0.69
3	**Beta**	3.47	0.65
4	**Qabalan**	3.13	0.65

It is clear from the above table that Huwwara & Asira which received CM strategies had the highest means were in Asira center (4.27), followed by Huwwara center (3.69), and those clinics who did not receive CM intervention Beta center (3.47) and the least in Qabalan center with a mean (3.13), while the highest standard deviation (1.01) was in Huwwara and the least in Qabalan (0.65).

As it turns out, there are out warded differences between the means of centers providing services, and to insure this difference is statistically significant, One Way Anova was used and the results as follow;

Table (5.25): F test for Question five

Question five		Sum of Squares	DF	Mean Square	F	Sig.
Waiting time	Between Groups	26.154	3	8.718	14.247	0.000
	Within Groups	90.564	148	0.612		
	Total	116.719	151			

We notice that the result of F the former table equals (14.247) which is significant (0.00) that is less than 0.05 meaning that there are differences among the centers in waiting time where study has been approached which are: Huwwara, Beta, Asira and Qabalan.

To know the differences, we use LSD Post-Hoc test to the level of difference and the results are as follow:

Table (5.26): LSD Post-Hoc test for the differences according to waiting time

Center	Huwwara	Asira	Beta	Qabalan
Huwwara	----------	- 0.578 *	0.219	0.561 *
Asira		----------	0.79 *	1.140 *
Beta			----------	0.342
Qabalan				----------

The results of table (5.26) show that there are statistically significant differences $\alpha \leq 0.05$ between Huwwara and each of Qabalan and Beta in waiting time of services in favor of Huwwara, and Huwwara a difference between Huwwara and Asira in favor of Asira, a difference between Asira and each of Qabalan and Beta in favor of Asira, also there was a difference between Beta and Qabalan in favor to Beta.

Research question six: Is there a significant difference in the satisfaction with the knowledge gained by patients who were exposed to diabetic education, communication and information with other comparable governmental clinics that were not exposed to CM?

To answer the sixth question, analysis was done to the responses of the respondents, and means (M) and standard deviations (SD) were calculated to the centers according to learning and communication, and were as follows;

Table (5.27): Learning and communication means and standard deviations

No:	Center	Mean	S. Deviation
1	**Huwwara**	4.06	0.55
2	**Asira**	4.14	0.68
3	**Beta**	3.57	0.49
4	**Qabalan**	3.25	0.41

It is clear from the above table that Huwwara & Asira which received CM strategies had the highest means were in Asira center (4.14), followed by Huwwara center (4.06), and clinics that did not receive CM intervention Beta center (3.57) and the least in Qabalan center with a mean (3.25), while the highest standard deviation (0.68) was in Asira and the least in Qabalan (0.41).

As it turns out, there are out warded differences between the means of centers providing services, and to insure this difference is statistically significant, One Way Anova was used and the results as follow;

Table (5.28):): F test for Question six

Question six		**Sum of Squares**	**DF**	**Mean Square**	**F**	**Sig.**
Learning and communication	Between Groups	20.539	3	6.846	22.956	0.000
	Within Groups	44.139	148	0.298		
	Total	64.678	151			

We notice that the result of F the former table equals (22.956) which is significant (0.00) that is less than 0.05 meaning that there are differences among the centers in

learning and communication where study has been approached which are: Huwwara, Beta, Asira and Qabalan.

To know the differences, we use LSD Post-Hoc test to the level of difference and the results are as follow:

Table (5.29): LSD Post-Hoc test for the differences according to learning and communication

Center	Huwwara	Asira	Beta	Qabalan
Huwwara	----------	- 0.078	0.49*	0.81 *
Asira		----------	0.57 *	0.89 *
Beta			----------	0.319*
Qabalan				----------

The results of table (5.29) show that there are statistically significant differences at $\alpha \leq 0.05$ between Huwwara and each of Qabalan and Beta in learning and communication of services in favor of Huwwara, and a difference between Huwwara and Asira in favor of Asira, also a significant difference between Asira and each of Qabalan and Beta in favor of Asira, also there was a significant difference between Beta and Qabalan in favor to Beta.

Research question seven: Is there a significant difference in patients satisfaction with the cleanliness in the clinics exposed to community mobilization compared to patients in other comparable governmental clinics were not exposed to CM?

To answer the seventh question, analysis was done to the responses of the respondents and means (M) and standard deviations (SD) were calculated to the centers according to cleanliness, and were as follows;

Table (5.30): Cleanliness means and standard deviation

No:	Centers	Mean	S. Deviation
1	**Huwwara**	3.85	0.81
2	**Asira**	4.24	0.66
3	**Beta**	3.65	0.48
4	**Qabalan**	3.48	0.59

It is clear from the above table (5.30) that Huwwara & Asira where CM strategies received the highest means were in Asira center (4.24), followed by Huwwara center (3.85), and those clinics who did not receive CM intervention Beta center (3.65) and the least in Qabalan center with a mean (3.48), while the highest standard deviation (0.81) was in Huwwara and the least in Beta (0.48).

As it turns out, there are out warded differences between the means of centers providing services, and to insure this difference is statistically significant, One Way Anova was used and the results as follow;

Table (5.31): F test for Question seven

Question seven		Sum of Squares	DF	Mean Square	F	Sig.
Cleanliness	Between Groups	12.027	3	4.009	9.443	0.000
	Within Groups	62.863	148	0.425		
	Total	74.863	151			

We notice that the result of F the former table equals (9.443) which is significant at (0.00) that is less than 0.05 meaning that there are differences among the centers in services provided where study has been approached which are: Huwwara, Beta, Asira and Qabalan.

To know the differences, we use LSD Post-Hoc test to the level of difference and the results are as follow:

Table (5.32): LSD Post-Hoc test for the differences according to cleanliness

No:	Center	Huwwara	Asira	Beta	Qabalan
1	**Huwwara**	----------	- 0.38*	0.205	0.36 *
2	**Asira**		----------	0.58 *	0.75 *
3	**Beta**			----------	0.16
4	**Qabalan**				----------

The results of table (5.32) show that there are statistically significant differences at $\alpha \leq 0.05$ between Huwwara and each of Qabalan and Beta in cleanliness in clinics in favor of Huwwara, and a difference between Asira and each of Qabalan and Beta in favor of Asira, there was a difference between Beta and Qabalan in favor to Beta. Also there was a significant difference between Asira and Huwwara in favor to Asira.

Research question eight: Is there a significant difference in patients' satisfaction with privacy in the clinics exposed to community mobilization compared to patients in other comparable government clinics not exposed to?

To answer the eighth question, analysis was done to the responses of the respondents and means (M) and standard deviations (SD) were calculated to the centers according to privacy, and were as follows;

Table (5.33): Privacy means and standard deviation

No:	Center	Mean	S. Deviation
1	**Huwwara**	3.73	0.94
2	**Asira**	4.25	0.66
3	**Beta**	3.7	0.53
4	**Qabalan**	3.28	0.64

It is clear from the above table that Huwwara & Asira which received CM strategies had the highest means were in Asira center (4.25), followed by Huwwara center (3.73), and those clinics who did not receive CM intervention Beta center (3.7) and the least in Qabalan center with a mean (3.28), while the highest standard deviation (0.94) was in Huwwara and the least in Beta (0.53).

As it turns out, there are out warded differences between the means of centers providing services, and to insure this difference is statistically significant, One Way Anova was used and the results as follow;

Table (5.34): F test for Question eight

Question eight		Sum of Squares	DF	Mean Square	F	Sig.
Privacy	Between Groups	17.896	3	5.965	11.756	0.000
	Within Groups	75.102	148	0.507		
	Total	92.998	151			

We notice that the result of F the former table equals (11.756) which is significant (0.00) that is less than 0.05 meaning that there are differences among the centers in services provided where study has been approached which are: Huwwara, Beta, Asira and Qabalan.

To know the differences, we use LSD Post-Hoc test to the level of difference and the results are as follow:

Table (5.35): LSD Post-Hoc test for the differences according to privacy

No:	Center	Huwwara	Asira	Beta	Qabalan
1	Huwwara	----------	- 0.519	0.32	0.44 *
2	Asira		----------	0.55 *	0.96 *
3	Beta			----------	0.41*
4	Qabalan				----------

The results of table (5.35) show that there are statistically significant differences at $\alpha \leq 0.05$ between Huwwara and Qabalan and deference with Beta in privacy in clinics in favor of Huwwara, and a significant difference between Asira and each of Qabalan and Beta in favor of Asira, there was a significant difference between Beta and Qabalan in favor of Beta.

5.5 Summary

This chapter introduced the results of the statistical analyses of the questionnaire in this study, socio-demographic factors and answered the study questions of this study.

Chapter Six: Discussion and Implications

6.1 Introduction

In this chapter, the researcher will discuss the main findings and results. The study main aim was effectivness of community mobilization strategies on diabetic patient satisfaction with selected governmental health centers in Nablus villages and factors affecting their satisfaction. This research study used a pretested questionnaire on 152 diabetic participants who attend diabetic center to benefit from related services during period December 2011- January 2012.

The participants were selected from 4 centers of all those centers that provide diabetic services at targeted Nablus villages. The results revealed relatively high level of general satisfaction with the service provided from governmental providers 71.5% were satisfied or strongly satisfied with diabetic health services in Nablus villages from different centers applied CM and who did not apply while only 28.5% were not satisfied or strongly not satisfied with this service.

A study conducted in 2011 at primary health care clinics in Ramallah district with the aim to assess the level of married female's satisfaction with reproductive health services in Ramallah district, and to compare levels of satisfaction among governmental and nongovernmental clinics revealed relatively high level of general satisfaction with the services provided from different providers; 93.2% were satisfied or strongly satisfied with reproductive health services in Ramallah district from different kinds of providers while only 2.8% were not satisfied or strongly not satisfied with this service. (Abu Mohsen, 2011).

6.2 Discussing satisfaction domains

Respondents of this study expressed their satisfaction level with eight important satisfaction factors; quality of service provided, services delivered from the service provider, cleanliness, waiting time, accessibility to the service center, privacy during providing the service, learning and communication, and community participatation rate.

In the first domain “quality of the service provided”; the participants showed high level of satisfaction with the quality of the services provided. The average mean of quality items was (3.92). The range of means was (3.76–4.09). The highest item the participants were satisfied with was "You were tested for diabetes before seeing the physician" with a mean of (4.09) degree while the lowest item participants were satisfied with was "Health problem you came for is treated or within treatment" with a mean of (3.76).

From these results, it could be concluded that the testing diabetic patients before seeing the physician in the centers affect participants’ level of satisfaction and considered it the main aspect of the quality of the services provided to them. In spite of the lower level of participants’ satisfaction with the item "Health problem you came for is treated or within treatment", it was clear that the means of all items were very close to each other with no significant difference between the highest and lowest items means. Other statements in this domain are close to each other and there is no big difference, signifying that the responses of the respondents in this field are extremely satisfied.

In comparison between centers that received CM and those did not receive CM, slight deference in satisfaction was revealed as Asira has the highest mean (4.32) and SD (0.48). Huwwara had the second level of satisfaction with mean (4.09) and SD (0.58), then Beta with mean (3.95) and SD (0.46) and Qabalan showed the lowest level of satisfaction with mean (3.52) and SD (0.62).

In this domain, all centers are satisfied with quality of services but the centers that received community mobilization are more satisfied than centers which didn’t receive community mobilization, because most answers of questions in Huwwara and Asira are strongly agreed, suggesting that community mobilization may increase satisfaction, but there is no base line to judge whether this change is due to community mobilization. Another reason could be that patients who participated in Asira and Huwwara were more educated than other patients in other centers and this leads to satisfaction.

Comparing with related studies, in the study done in the period 2004-2005 by Iftekhar et al., 2010 in Karachi, Pakistani hospitals, level of satisfaction of the patients with the outpatient health services provided relatively high level of satisfaction, quality of service was part of the recommendations from the study that contributes to increase patient’s satisfaction (Iftekhar et al., 2010).

In another study, relatively high level of satisfaction with the quality of services provided at Ramallah district could be due to the implementation of the primary health care principles and needs made by different providers of the Palestinian health care sector in cooperation with international agencies and the WHO, where there was an increase of 52.9% on the number of PHCS in 2009 compared to 1994 in the public sector (5746 person/ center in 2000 to 5679/center in 2009 in spite of the population increase) (MoH, 2009).

Besides, FROJD et al., (2011), results were inadequate quality was identified for 15 out of 24 items, information given on treatment and examination results, opportunities to participate in decisions related to care and information on self-care. Patients with emergency admissions reported lower scores for quality of information and doctors care than did patients with planned admissions. Conclusion results from the present survey identified areas in need of quality improvement and differences in perceived care quality between patients. Quality of care must be developed in close collaboration with other healthcare professionals; in this respect, nursing managers could play an important role. Implications for nursing management were that nursing managers could play a more active part in measuring quality of care, and in using results from such measurements to develop and improve quality of care.

In the second domain "Cleanliness"; the participants showed the high level of satisfaction in the cleaning in these clinics. The average mean of cleaning items was (3.80). The range of means was (3.47–3.98). The highest item the participants were satisfied with was "Health workers use specific clean tools" with a mean of (3.98) degree, while the lowest item participants were satisfied with was "Circumscription of center was clear" with a mean of (3.47).

Commenting on these results, it could be concluded that the staff use clean tools, clean waiting area, and clean bed sheets in the centers which may affect participants' level satisfaction and they consider it very important to see clinics clean and this generates their psychological comfort which eventually may reflect patient satisfaction with the service provided to them. In spite of the lower level of participants' satisfaction with the item "Circumscription of center was clear", non-hygienic clinics show that community mobilization providers must raise awareness of the disease and pay attention to clean the area around the clinics and this is within the community mobilization strategies. It was clear that the means of all items were very close to each other with no significant difference between the highest and lowest

items' means. Other statements in this domain are close to each other and there is no big difference, signifying that patients are really satisfied.

In comparison between centers that received CM and those did not receive CM, moderate deference in satisfaction was revealed as Asira has the highest mean (4.24) with SD (0.66). Huwwara had the second level of satisfaction with mean (3.85) and SD (0.81), then Beta with mean (3.65) and SD (0.48) and Qabalan showed the lowest level of satisfaction with mean (3.48) and SD (0.59).

In this domain, all centers are satisfied with cleanness, but the centers that received community mobilization are more satisfied than centers that didn't receive community mobilization, because most answers of questions in Huwwara and Asira are strongly agreed, and another reason that people in Asira and Huwwara could be more educated and more participative in community mobilization project meaning that community mobilization may shape satisfaction, but there is no base line to judge whether this change is due to community mobilization.

In comparing study, Al-Shrif study 2008, showed that 80.5% of respondents rated the level of cleanliness of the toilets, showers and floors from good to very good in nongovernmental hospitals, while 58.1% of respondents in governmental hospital rated the cleanliness of these areas from very poor to fair.

In the third domain "waiting time"; participants showed they were highly satisfied with the waiting time in these clinics. The average mean of waiting time items was (3.64). The range of means was (3.27-4.07). The highest item the participants were satisfied with was "Registration producers were fast" with a mean of (4.07) degree, while the lowest item participants were satisfied with was "Waiting before entering the test room was appropriate" with a mean of (3.27).

We can conclude from these results, that the "Registration producers were fast" in the centers affect participants' level of satisfaction and they deem it the main aspect of the waiting time of the services provided to them. The lower level of participants' satisfaction with the item "Waiting before entering the test room was appropriate", this means that patients are enormously satisfied with registration department, but they kept reservation on time waiting for laboratory tests before work and also before entering the doctor's room and this requires hiring further laboratory technicians and increase the work day diabetes clinics.

It was clear that the means of all items were moderate close to each other with slightly significant difference between the highest and lowest items means. Other

statements in this domain are close to each other and there is no big difference, telling that the patients are satisfied.

In comparison between centers that received CM and those did not receive CM, slight deference in satisfaction was revealed as Asira had the highest mean (4.27) and SD (0.69). Huwwara had the second level of satisfaction with a mean (3.69) and SD (0.58), then Beta with mean (3.47) and SD (0.71) and Qabalan showed the lowest level of satisfaction with a mean (3.13) and SD (0.65).

In this domain, all centers are satisfied with waiting time but the centers that received community mobilization are more satisfied than centers that didn't receive community mobilization, because nearly all answers of questions in Huwwara and Asira are strongly agreed. And that, mainly due to the presence of nurse specific to diabetic patients (included in the community mobilization program) cared about them, such as taking pressure and weight and sometimes in helping to draw blood and regulate the entry of patients into the doctor's room in Asira and Huwwara clinics, and this contributes to the acceleration of receiving service, reduce waiting time and feel satisfied, meaning that community mobilization may affect satisfaction, but there is no base line to judge whether this change is due to community mobilization.

In a comparing study, (Kurata ,1992) compared patient and provider satisfaction with medical care and waiting time in a large family practice residency program. While 97% of patients were satisfied with their medical care, approximately 8% of patients and 22% of providers were dissatisfied with waiting times. An estimate of waiting times by dissatisfied patients was 41.8 minutes.

This study does not agree with a study conducted by Al Sharif et al., in 2008 in Nablus city, Palestine with the objectives were to measure patients' satisfaction with services provided by hospitals at Nablus city, patients who were waiting long time (more than one hour), were less satisfied than the others, while obstetric patients were found to be the most.

In the fourth domain "services delivered"; participants showed a moderate satisfaction with the services provided. The average mean of services delivered item was (3.46). The range of means was (2.22–4.39). The highest item the participants were satisfied with was "Comprehensive test (Cumulative diabetes, Cholesterol, fat) is being carried out each visit" with a mean of (4.39) degree, while the lowest item participants were

satisfied with was "ECG is done periodically" with a mean of (2.22). The total mean of all paragraphs (3.46) indicates a moderate degree of agreement of this level from all participants.

From these results, it could be concluded that the tested diabetic patients in each visit "FBS is done each visit and a comprehensive test each six month" in the centers affect participants' level of satisfaction and they believe it the main aspect of services provided to them. In spite of the lower level of participants' satisfaction with the item "ECG is done periodically", "Your feet are being checked regularly" and "You are submitted to a specialist doctor (heart, kidney, endocrine glands", it was clear that the means of these three items ((2.61)(2.42)(2.22) respectively, were very close to each other and very low indicating that all patients were not satisfied in these three items meaning that the services provided to diabetic patients are not sufficient and ought to care about them and provide medical specialists to visit clinics periodically and must give great importance to examine the forefeet for patients because most problems of the patients are in the heart, eyes and feet. Other statements in this domain are close to each other and there is no big difference, signifying that the patients are therefore satisfied.

In comparison between centers that received CM and those did not receive CM, slight deference in satisfaction was revealed, as Asira has the highest mean (3.8) and SD (0.81). Huwwara had the second level of satisfaction with mean (3.52) and SD (0.65), then Beta with mean (3.4) and SD (0.57) and Qabalan showed the lowest level of satisfaction with mean (2.97) and SD (0.62).

In this domain, all centers are satisfied with services delivered**,** but the centers that received community mobilization are more satisfied than centers that didn't receive community mobilization, because most answers of questions in Huwwara and Asira are strongly agreed. But, as we have said formerly, there are three axes of all patients in all clinics who are not satisfied even clinics that have implemented the community mobilization and indicating that work must be to increased to delineate the patients about the importance of this CM for them and refer to the decision-makers to work to find out solutions to this problem.

In the fifth domain "privacy"; the participants showed satisfaction from moderate to high level with the privacy of the services provided. The average mean of privacy items was (3.67). The range of means was (3.42–3.98). The highest item the participants were satisfied with was 'Generally, the team maintains the information

confidentially' with a mean of (3.98) degree, while the lowest item participants were satisfied with was 'To protect your privacy, the health worker closed the door' with a mean of (3.42)

This indicates that patients are psychologically comfortable or the degree of satisfaction is good for them because nobody briefs on their files and their hygiene, while privacy remains reserved but in some centers it was incomplete where the doctor does not close the door and this affects the communication with the doctor where patients cannot ask questions to the doctor. This affects the privacy of the patients with that room is equipped with a means of privacy where there are curtains and bed covers. Upon this, observers must emphasize the doctor to close the door or set door stopper to close the door after each patient

In comparison between centers that received CM and those did not receive CM, slight deference in satisfaction was revealed as Asira has the highest mean (4.25) and SD (o.66). Huwwara had the second level of satisfaction with mean (3.73) and SD (0.94), then Beta with mean (3.7) and SD (0.53) and Qabalan had the lowest level of satisfaction with mean (3.28) and SD (0.64).

In this domain, all centers are satisfied with privacy but the centers that received community mobilization are more satisfied than centers that didn't receive community mobilization, because most answers of questions in Huwwara and Asira are strongly agreed , this means that community mobilization may affect satisfaction, but there is no base line to judge whether this change is due to community mobilization. Another reason could be that patients who participated in Asira and Huwwara were more educated than other centers and this leads to satisfaction.

And another reason why the number of working days in clinics within their CM is higher though the four centers selected are central ones for patients with diabetes and this leads to the division of patients better and comfortable leading to patient satisfaction.

In comparing our study with a study done in Egypt that investigated the factors which influenced client's satisfaction with primary health care services, it was found that the level of privacy in the consultation room was described as unsatisfactory by 33% of Egyptian clients (Gadallah, 2003).This indicates that the participants of this study were more satisfied with the level of privacy than the Egyptian participants.

In this domain “accessibility ”; the participants showed high level of satisfaction with the accessibility of the services provided. The average mean of accessibility items was (3.56). The range of means was (2.97–4.02). The highest item the participants were satisfied with was 'It was safe to come to the center’ with a mean of (4.02) degree, while the lowest item participants were satisfied with was ‘The existence of a parking encourages you to attend the center to take the service’ with a mean of (2.97).

According to these results, it could be concluded that it is easy to access to the center in terms of location and safety during going and returning, and the low cost of transportation. This contributed to increase patient satisfaction, but draw attention to the access to the physician when a health problem happens with the patient at home, it is not easy to reach him and that because of the presence of a solitary doctor in the clinic. Also, and parking must be available close to the clinic.

In comparison between centers that received CM and those did not receive CM, moderate deference in satisfaction was revealed as Asira had the highest mean (3.95) and SD (0.96). Huwwara had the second level of satisfaction with a mean (3.74) and SD (0.77), then Beta with mean (3.32) and SD (0.61) and Qabalan showed the lowest level of satisfaction with mean (3.2) and SD (0.55).

In this domain, all centers are satisfied with accessibility but the centers that received community mobilization are more satisfied than centers that didn’t receive community mobilization, because most answers of questions in Huwwara and Asira are strongly agreed , this implicates that community mobilization may affect satisfaction, but there is no base line to judge whether this change is due to community mobilization. Another reason is that CM clinic was moved to a better location and this is an important reason for patient satisfaction.

In 2003, a study by the Eastern Mediterranean done in Egypt that compares patient satisfaction with primary health care services and identifies factors associated with patient satisfaction in two health districts in Egypt where a project for upgrading primary health care services had been running for 3 years, patient satisfaction was high for accessibility, and performance of doctors and nurses. (Gadallah et al., 2003).

A study done in 2007, in Thailand, the study was conducted to describe patient satisfaction towards outpatient health care services provided showed that overall satisfaction was 86.67. The patients were most satisfied from convenience 84% while least from courtesy 76.1%.

In the domain "Learning and communication"; the participants showed a moderate to high satisfaction with the learning and communication of the services provided. The average mean of quality items was (3.77). The range of means was (2.59–4.15). The highest item the participants were satisfied with was "Communication level between patient and staff was good" and "You feel staff respect" and "Patients' trust in staff is good" with a mean of (4.15) degree, while the lowest item participants were satisfied with was "Did you have a health education outside the center" with a mean of (2.59).

From these results, it could be concluded that level of satisfaction is moderate to high and they consider it the main aspect of the learning and communication of the services provided to them. In spite of the lower level of participants' satisfaction with the item 'Did you have a health education outside the center', it was clear that the means of all items were very close to each other.

And also confidence staff healer is excellent, and staff answers all the questions posed by patients, who overall feel comfortable. But, there are things that should be taken into consideration; a process that health education inside and outside the center where the patients are moderately satisfied and that communication between patients and staff and the doctor is good for health education and must work mechanism to extend awareness more and change policy brochures and intensify seminars awareness and exploit the presence of patients and the exploitation of long waiting time inside the clinics. This needs cooperation between the decision-makers in the health centers and the owners of programs applied in these areas and also noted the existence of publications within the centers but patients, unfortunately, do not read and they need someone to guide and aware them orally.

In comparison between centers that received CM and those did not receive CM, slight deference in satisfaction was revealed as Asira has the highest mean (4.14) and SD (0.68). Huwwara had the second level of satisfaction with mean (4.06) and SD (0.55), then Beta with mean (3.57) and SD (0.49) and Qabalan had the lowest level of satisfaction with mean (3.25) and SD (0.41).

In this domain, all centers are satisfied with learning and communication but the centers that received community mobilization are more satisfied than centers that didn't receive community mobilization, because most answers of questions in Huwwara and Asira are strongly agreed , this means that community mobilization may affect satisfaction, but there is no base line to judge whether this change is due to

community mobilization. Another reason could be that patients who participated in Asira and Huwwara were more educated than other centers and this leads to satisfaction, but health education needs to be reconsiderated, while communication between staff and patients is grossly excellent.

In the eighth domain 'Community participate'; the participants showed satisfaction from the low level with the community participation. The average mean of community participate items was (2.28). The range of means was (2.19–2.39). The highest item the participants were satisfied with was 'Did you feel the change in the nature of services provided for the better in the clinic after the application of CM' and 'Did you feel a change in the treatment for the better by the medical staff after your participation in these committees' with a mean of (2.38) degree, while the lowest item participants were satisfied with was ‘Did your participation in community committees contribute in raising awareness to you and other patients’ with a mean of (2.19).

From these results, we notice that all the questions in that paragraph have low mean and this shows that community mobilization is not extended or that the patients or part of them had not heard in some centers and this because some of patients are new, so the program appliers must continue to clarify the concept of CM for patients internally and externally in the centers every now and then. Despite this result, the patients who have been involved in CM found a difference in the service provided before and after CM an felt change in treatment of the staff for the better as well as increased awareness of health and familiarize them with their illness correctly through their involvement in the program. But results of the centers not involved in CM were negative, as well as a difference between the patients and the patients who were on community mobilization. Based upon this, we point out to decision makers in both the Ministry of Health or program officers to increase the involvement of patients or the general public in the evaluation and monitoring of programs and identify more to people's priorities and health requirements.

In comparison between centers that received CM and those did not receive CM, slight deference in satisfaction was revealed as Asira has the highest mean (2.94) and SD (1.5). Huwwara had the second level of satisfaction with mean (2.66) and SD (1.2), then Beta with mean (1.46) and SD (0.76) and Qabalan had the lowest level of satisfaction with a mean (2.06) and SD (1.35).

In this domain, the centers are poorly satisfied with patient participation but the centers that received community mobilization are more satisfied than centers that didn't receive community mobilization, because most answers of questions in Huwwara and Asira are agreed, this means that CM may affect satisfaction, but there is no base line to judge whether this change is due to community mobilization. Another reason could be that patients who participated in Asira and Huwwara were more educated than other centers and this leads to satisfaction.

A comparison study in 2011, by Xu, in west Texas with the objectives to test whether concordance or discordance of patient participation between patients and physicians is associated with higher satisfaction, and to examine the effects of patients' and physicians' participatory styles on patients' satisfaction with their physicians, conducted on a sample consisted of 2,167 elderly patients. He found that controlling for confounding factors, a higher participatory decision making (PDM) score was associated with a higher rating of patient satisfaction with physicians. A higher patient participation score was related to a lower physician satisfaction rating. The combined effect of patients' and physicians' participation styles indicated that for a low patient participation score, a high PDM score was not needed to produce high satisfaction. The greater the discordance in this direction, the higher the satisfaction. However, with a high patient participation score, only an extremely high PDM score would produce relatively high satisfaction. The author concludes that participatory physicians and patient-physician communications concerning patient participation can promote higher satisfaction.

6.3 Summary

This chapter presented the discussion and implications of the major findings related to this study with the comparison to the results of other studies conducted in the related fields and to the related conceptual models. Consistency and inconsistency of the findings are also compared to other studies related to this field.

Chapter Seven: Conclusions and Recommendations

7.1 Introduction

Patient satisfaction is an increasing important issue both in evaluation and shape of health care, it should be carried out routinely in all aspects of health care to improve quality of health care services .

This is the first study in Nablus and Palestine that has asked patients in diabetic centers about specific aspects of health care and rate the level of diabetic patient satisfaction of services provided by centers after implementing community mobilization in Huwwara and Asira centers comparing with other centers not implementing community mobilization in Beta and Qabalan, in addition to all the centers surveyed are central centers offering services for patients with diabetes.

The study highlighted to planners and decision makers several shortcomings that need to be improved.

This level of satisfaction is consistent with other research studies locally and internationally and could be justified with the competition among centers in terms of champion center, and quality of services while providing diabetic services.

7.2 Conclusions

In this research study, 152 diabetic patients participated in this study as a prerequisite for the master degree in health policies and management program with the main aim was to explore the effect of community mobilization strategies on patient satisfaction with governmental health services provided to diabetic patients in selected Nablus villages to assess their satisfaction level with diabetic services provided in Nablus district.

Participants showed relatively very high level of satisfaction. There was high level of overall agreement among participants' answers on all the 8 domains studied in this research. The means ranged from 3.67 to 4.09. The “quality of service provided” was

the dimension that had the highest satisfaction level. On the other hand, "community participate" domain was the lowest in level of satisfaction for the participants.

7.3 Recommendations

From this study, the researcher came up with the following recommendations:

- The importance of diabetic health services in communities indicates the need for making those services available in terms of coverage and quality in the majority of primary health care centers.
- There is a need for community mobilization and education about the importance of diabetic health issues and how to benefit from the related services.
- There is a need for training for different types of providers and staff members at the national level, to enhance the quality of the services provided according to the international standards.
- Notably, there is an impact in areas that implemented community mobilization, thus the Ministry of Health must enforce this program to the rest of the centers in Nablus city and the rest of the provinces.
- Community mobilization providers have to raise awareness for cleanliness, especially around the centers and not just seminars, but volunteer work days for cleanliness inside and outside the centers involving the local community in all its factions (the local council and youth centers and ministries).
- Service providers; both the Ministry of Health and program appliers have to contribute to reducing the time spent by patient and increasing the number of days for specialist doctors, allocating a nurse for diabetic patients in each center and increase the number of laboratory technologists and provide a pharmacist in each clinic rather than the nurse bearing the burden of drug distribution.
- Provision of ophthalmologist, cardiologist and orthopedist for feet in the centers implementing community mobilization or other centers.
- Sustainability of provision of pharmaceuticals in clinics on a regular basis and take heed not declining, as come about in some centers.
- Emphasis on respect for the privacy of staff to patients, especially locking up the door after the patient enters the examination room and give him sufficient

time and ensure the availability of privacy tools such as blankets, curtains, clean bed sheets in the examination room.

- The exertion of a mechanism to facilitate access to specialists when an emergency problem occurs to patients in all centers.
- Increasing communication between staff and patients through work involvement more educational and scientific days and improving health education inside and outside centers.
- Boosting community in decision-making process and contributing to the evaluation of programs, identifying its needs and increasing awareness through community mobilization definition in all the centers involved in this process as well as other centers.
- Ministry of Health obligation to provide accurate periodic statistics for the number of patients and not just the number of visits.
- Ministry of Health application to use champion center strategy to motivate the medical staff to provide better services and improve the treatment of patients which is reflected more on patient satisfaction.
- Healthcare service providers must continually capture, measure and evaluate patient satisfaction through a range of agreed mechanisms and the results of these evaluations should be analyzed and inform the service planning process.
- Organizations should integrate the learning opportunities from customer feedback into their quality improvement plans.
- A Patient Satisfaction Toolkit should be developed to ensure that best practice information in relation to all facets of patient satisfaction (instruments, models, guidelines, feedback) is centrally collated and widely available.
- This is the first study in this area in Palestine and can be a background for any subsequent study and can manage studies and be the background for any subsequent study.

7.4 Summary

Based on the findings obtained from the study results, post discussion and comparison to other studies done in the field and theoretical model; this chapter presented the conclusions, implications and future recommendations.

References

1. Abu Mohsen .A. (2011). *Married Female Satisfaction with Reproductive Health Services in Ramallah District at the West Bank of Palestine.* Al-Quds university. Palestine.
2. ACQUIRE Project.(2006*). Community Mobilization: Improving Reproductive Health Outcomes,* New York, NY 10001 U.S.A.
3. Acuña, D. L., C. Gattini, M. Pinto, and B. Andersson. (2001). *Access to Financing of Health Care: Ways to Measure Inequities and Mechanisms to Reduce them*. In Equity & Health. Views from the Pan
4. Al- Sharif, B. (2008). *Patient's Satisfaction With Hospital Services At Nablus District*, West Bank, Palestine, An-Najah National University, Palestine.
5. Al-Badayneh, D. (2009): *Patient Satisfaction in Jordanian Hospitals,* Mu'tah University, Amman.
6. Allen G. Bluman. (1995*). Elementary Statistics- A step by step approach*, 2nd edition.
7. Al-Nozha MM.et,al (2004). *Coronary artery disease Saudia Arabia*, Saudi medical journal, 2004,25(9):1165-71
8. Alth journal, WHO volume 48/4 December 2010 14: 2-12
9. Alyson Callan, Roland Littlewood. (1998). *Patient Satisfaction: ethnic origin or explanatory model*?-The International Journal of Social Psychiatry; 44 no1: 1-11.
10. American Sanitary Bureau (Occasional Pub. No. 8). Washington, DC: Pan American Health Organization (PAHO).
11. Anderson RT, Weisman CS, Scholle SH, Henderson JT, Oldendick R, Camacho F. (2002).*Evaluation of the quality of care in the clinical care centers of the National Centers of Excellence in Women's Health.* Women's Health Issues 12(6):287-90.
12. Andrew, F., Laing J., and Stoekel J. (1983*). Handbook for Family Planning Operations Research Design;* Contents and Outlines for Preparing a Research Proposal: The Population Council.
13. Andrus, D. (1984), "Factors Affecting Rural Consumers' Satisfaction With

Medical Care," Journal of Health Care Marketing, 4 (Summer): 7-15.

14. Bamgboye, E, Jarallah, J. (1994). Long-waiting outpatients: Target audience for health education. Patient Educ and Counsel;23:49-54.
15. Barbara A.B, Margaret E.G. (2005). *Mobilizing the Community*. Ohio State University Fact Sheet Extention.
16. Bar-Dayan Y, Leiba A, Weiss Y, Carroll JS, Benedek P: *Waiting time is a major predictor of patient satisfaction in a primary military clinic.*
17. Bartle, Phil. *Empowering Communities*. http://www.scn.org/cmp/modules/emp-ce.htm (accessed Jan 11, 2011)
18. Ben Sira, Z. (1976). *The function of the professional's effective behavior in client satisfaction: A revised approach to social interaction theory;* Journal of Health and social behavior, 17: 3-11.
19. Bennett-Staub, Amy. (2002). *Quality Management- Available from:* http://nypisys.cpmc.columbia.edu/AR2001/Qualitymgmt.htm
20. Berengere, N, et al, (2007*). Improving Interpersonal Communication Between Health Care Providers and Clients*, USA.
21. Bitner, M. and Hubbert A. (1994). *Encounter satisfaction versus overall satisfaction versus quality, thousand oaks* , C.A.SAGF ,1194.
22. Brady, K.; Robertson J.(2001). *Searching for a Consensus on the Antecedent Role of Service Quality and Satisfaction: An Exploratory Cross-Sectional Study.* Journal of Business Research.; 51: 53-60
23. Brady, M.K., & Cronin, J.J. Jr. (2001). *Some new thoughts on conceptualizing perceived service quality: A hierarchical approach.* Journal of Marketing, 65(3), 34–49.
24. Brown, Lori DiPrete .(1993). *Assessing the Quality of Services, Primary Health Care Management Advancement Program, Users' Guide Module 6*; Client Satisfaction:117-19.
25. Bryony, B, et al, (2009): *Technical Report for SCIE Research Review on Access, Acceptability and Outcomes Services, interventions to support parents with mental health problems and their families,* UE.
26. Burghard, S. (1986). *Organizing for Community Action*, University of Michigan School of Social Work, Sage Publications.

27. Calnan M. (1988). Towards a conceptual framework of lay evaluation of health care. Social Science & Medicine; 27(9): 927-933

28. Campbell SM, Braspenning J, Hutchinson A, Marshall M. (2002*). Research methods used in developing and applying quality indicators in primary care. Quality and Safety in Health Care.* 11(4), 358-64.

29. Carey RG, Seibert JH. (1993). *A patient survey system to measure quality improvement: Questionnaire reliability and validity*. Med Care. ;31(9):834-45. Chapter 12, Chi- Square, 419- 428.

30. Choi. K.S., Cho. W.H., Lee S.H., Lee. H., Kim.C. (2004). *The Relationship among Quality, Value, Satisfaction and Behavioral Intention in Health Care Provider Choice: A South Korean Study,* Journal of Business Research, 57,913-921.

31. Cohen G.(*1996*). *Age and health status in a patient satisfaction survey. Soc Sci Med; 42: 1085–1093.*

32. Crow, R., Storey, L., and PagH., (2003). *The measurement of patient satisfaction: Implications for health service delivery through a systematic review of the conceptual, methodological and empirical literature.* Health Technology Assessment; 6(32).

33. Culnan, M. J., & Armstrong, P. K. (1999*). Information privacy concerns, procedural fairness, and impersonal trust: An empirical investigation. Organization Science*, 10(1), 104-115.

34. Culnan, M. J., & Bies, R. J. (2003). *Consumer privacy: Balancing economic and justice considerations. Contemporary Perspectives on Privacy: Social, Psychological, Political, 59*(2), 323-342.

35. *Da Costa D, Clarke AE, Dobkin PL et al. The relationship between health status, social support and satisfaction with medical care among patients with systemic lupus erythematosus.* Int J Qual Health Care *1999; 11: 201–207.*

36. Dansky KH, Miles J*: Patient satisfaction with ambulatory healthcare services: waiting time and filling time. Hosp Health Serv Adm* 1997, **42**(2)**:**165-177. PubMed Abstract

37. Davis RM, Wagner EG, Groves T. (2000). *Advances in managing chronic disease.* British Medical Journal.; 320:525 – 526

38. Department of Health. (2004). *Improving Chronic Disease Management.*

Electronic access(25/10/2006).http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4075214&ch k=YxS1Yj.

39. Dinesh, B., Grenade, J. and La Dazzan P. (2000). *Psychiatric inpatients' satisfaction with eservices: A pilot study*; International Journal of Psychiatry in Clinical Practice, 4: 327-332.
40. Donabedian, A. (1980). *The definition of quality and approaches to its assessment*. Ann Arbor, MI: Health Administration Press.
41. Donabedian, A. (1988). The *quality of care: How can it be assessed? Journal of the American Medical Association, 260,* 1743–1748.
42. Donaldson, M. (1997). *Center to Improve Care of the Dying: Continuity of Care. http://www.gwu.edu/~cicd/toolkit/contin.htm (accessed October 29, 2011).*
43. Dye, Robert R., John S. Wood. (1981). *"A Different Game: Collaborating to Serve Youth at Risk,"* National Council of YMCAs, National Collaboration for Youth, *Journal of Voluntary Action Research*.
44. Eivind, M. (2003). Patient *centered method and self directed behavior change-Available from: http://www.uib.no/isf/people/paticent.htm.* Accessed online at 28 February 2011.
45. Elliot KM, Hall MC, Stile GW. (*1992*). *Service quality in the health care industry: how are hospitals evaluated by the general public?* Journal of Hospital Marketing. *;7:*113*–124.*
46. Ellwood PM Jr, Paul BA. (*1986*). *But what about quality?* Health Aff (Millwood). *;*5*:*135*–140.*
47. Fan VS, Burman M, McDonell MB, Fihn SD. (2004). *Continuity of care and other determinants of patient satisfaction with primary care.* General Internal Medicine.
48. Fitzpatric R., Hopkins A . (1983*). Problems in the Conceptual Framework of Patient Satisfaction Research- an empirical exploration*; Sociology of health and illness. 5, 31983.
49. Fitzpatrick R. (1997). *The assessment of patient satisfaction. In: Jenkinson C (Ed) Assessment and Evaluation of Health and Medical Care*. Buckingham,

UK: Open University Press.

50. Fitzpatrick R. Surveys of patient satisfaction 1: *Important general considerations*. British Medical Journal (1991); 302:887.
51. Flagship project. *http://www.flagshipproject.org/* (Accessed online on at 21 January 2011).
52. Fro¨jd C., Swenne C.L., Rubertsson C., GunningbergL. & Wadensten B. (2011). *"Patient information and participation still in need of improvement: evaluation of patients' perceptions of quality of care"*.
53. Gadallah, M, et al, .(2003). *Patient Satisfaction with Primary Health Care Services in Two Districts in Lower and Upper Egypt.* Eastern Mediterranean Journal, v9 n3.
54. Goodman R. M., Speers M. A., Mcleroy K., Fawcett S., Kegler M., Parker E., et al. *Identifying and defining the dimensions of community capacity to provide a basis for measurement. Health Education and Behavior 1998;25:258–278.*
55. Gotlieb, J.; Grewal, D.; Brown, S.(1994). *Consumer Satisfaction and Perceived Quality Complementary or Divergent Constructs?* Journal of Applied Psychology.; 79(6):875–85.
56. Grabman,H-L., & Snetro, G. (2003*). How to Mobilize Communities for Health and Social Change: Field Guide*. Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs. Baltimore, USA. 264 pp.
57. Grimes, F. Patient Satisfaction. (2003).Guidelines. *The Measurement of Patient Satisfaction.* Health Strategy Implementation Project 2003.
58. Grönroos, C. (2000). *Service management and Marketing-A customer Relationship management approach*, Wiley.
59. Gross National Happiness. (1999). A *publication of The Centre for Bhutan Studies*.
60. Hall JA, Feldstein M, Fretwell MD, Rowe JW, Epstein AM.(*1990). Older patients' health status and satisfaction with medical care in an HMO population. Med Care; 28: 261–270.*
61. *Hall JA, Milburn MA, Epstein AM. A causal model of health status and satisfaction with medical care.* Med Care *1993; 31: 84–94.*
62. Halpin HA, Morales- Suarez-Varela MM., Martin –Moreno JM. ,*chronic disease prevention and the new public health* . Public health review 2010 ,32:120-154.

63. HANAN Project in Palestine (2005 – 2007). *quarterly reports Maternal and Child Health*.
64. Hays R.D., Davies A.R., Ware J.E. (1987). Scoring the medical outcomes study patient satisfaction questionnaire: PSQIII. National Center for Health Services Research (NCHSR). Southern Illinois University School of Medicine. USA.
65. Health Information Center (PHIC) (2010). *Health Annual Report*, Ministry of Health, Palestine.
66. Heleen, Owen and Frederick T. Miller. (1992). *Mobilizing Local Coalitions and Collaborations to Better Serve Children at Risk.* Boston: Institute for Responsive Education and Medford, Massachusetts: Lincoln Filene Center, Tufts University.
67. Hibbard JH, Mahoney ER, Stockard J, Tusler M. (2005*). Development and testing of a short form of the patient activation measure.* Health Service Research.; 40(6 Pt1):1918-30.
68. Hsieh M, Doner Kagle J. (1991*). Understanding patient satisfaction and dissatisfaction with health care*. Health and Social Work.; 164, 281-290.
69. Hughes J. (1994*). The Doctor –patient relationship: A Review excerpt from the dissertation- Organization and Information at the Bed Side.*
70. Hulka, B. and S. Zyzanski. (1982), *"Validation of Patient Satisfaction Scale,"* Medical Care, 20: 649-653.
71. Hulka, B., S. Zyzanski, J. Cassel and S. Thompson (1970). *"Scale for the Measurement of Attitudes Toward Physicians and Medical Care*," Medical Care, :429435. Huang XM**:** Patient attitude towards waiting in outpatient clinic and its applications**.** *Health Serv Manage Res* 1994, **7**(1)**:**2-8.
72. Iftikhar A,Siraj, D. (2010). *Patients' Satisfaction From The Health Care Services***.** Gomal Journal of Medical Sciences, Vol. 8, No. 1.
73. Indian journal Community Med. (2008). *Community perception and client satisfaction about the primary health care services in an urban resettlement colony of New Delhi* 33(4): 250–254.

74. Jenkins, H.S. (2002). *A piece of my mind. The morning after*. Journal of the American Medical Association 287(2): 161-162.
75. Jenkinson C, Coulter A, Bruster S, Richards N, Chandola T. (2002). *Patients' experiences and satisfaction with health care: results of a questionnaire study of specific aspects of care.* Quality and Safety in Health Care ;11:335-339.
76. Journal of Nursing Management 19, 226–236.
77. Journal of Public Health and Development (2007). *Patient Satisfaction towards Out Patient Department (OPD) Services Of Medicine Department* Vol. 5 No. 3
78. Juzoor Foundation for Health and Social Development. (2009). *Women's Health Surveillance Report,* Palestine. 2-69.
79. Keating, Thomas P., Arana, George A. (2003). *Maintaining patient satisfaction in a hospital organization; Source*: Hospital Topics, 73, Issue 4, p10,5p.
80. Keegan ,O., Mc Darby,V.,Tancy,A., and Mc Gee H.,2003 *community involvement in A/E satisfaction survey (submitted for publication).* Merdith J and Wood ,N. 1995.
81. Kurata, J, Nogawa, A, Phillips, D, Hoffman, S, & Werblum, M. (1992). *Patient and provider satisfaction with medical care*. J of Fam Prac;35:176-9.
82. Larson D., Rootman I. (1976). *Physicians' role performance and patient satisfaction*; Social Science and Medicine, 10: 29-32.
83. Leatherman, S. Sutherland, K. (2003). *The Quest For Quality. A Mid-Term Evaluation*
84. Letaief, M · Ben Hmida, A · Mouloud, B · Essabbeh, B · Ben Aissa, R · Gueddana, N. (2008): *Implementing a quality improvement program in a family planning centre in Monastir,* Tunisia. Eastern Mediterranean health journal.
85. Lin D. J., Sheu C. I., Pai Y. J., Bair A., Hung Y.C. and Chou J.M. (2009*).*"*Measuring Patients' Expectation and Perception of Quality in Lasik Services"*, Health and Quality of Life Outcomes, Vol.7.
86. Lin, B. Kelly, E.(1995). Methodological issues in patient satisfaction surveys . International Journal of Health care quality Assurance , vol.5. No.6 ,pp.25-31.

87. Linder-Pelz S. (1982). *Toward a theory of patients' satisfaction.* Social Science & Medicine; 16: 577–582. 37.
88. Locker, D. and Hunt D.. (1978). *'Theoretical and Methodological Issues in Sociological Studies of Consumer Satisfaction with Medical Care*," Social Science and Medicine, 12: 283-292.
89. Inui, T. S. and W. B. Carter (1985), "Problems and Prospects of Health Services Research on Provider-Patient Communication," Medical Care, 23: 521530.
90. Lule, G, et al, (2000): **Quality Of Care and its Effects on Utilization Of Maternity Services at Health Centre Level.** East African Medical Journal, Vol.77, No.5, pp.250-255.
91. Mackey T.A., Cole F.L. (1997): Patient Waiting Times In A Nurse Managed Clinic. *The Internet Journal of Advanced Nursing Practice*. Volume 1 Number 1. DOI: 10.5580/16b3.
92. Mahfouz AA, Abdelmoneim I, Khan MY, Daffalla AA, Diab MM, El-Gamal MN, Al-Sharif A. (2007). *Primary Health Care Emergency Services in Abha District of Southwestern Saudi Arabia,* Saudi Arabia1-12. East Mediterr Health Journal.;13(1):103-12.
93. Marshall GN, Hays RD, Mazel R. Health status and satisfaction with healthcare: results from the Medical Outcomes Study. Consulting and Clinical Psychology 1996; 64: 380-390.
94. Mawajdeh S, Al-Qutob R, Raad F. Assessment of the Quality of Prenatal Care Services: Women Perspectives. IDRC 1995; 1-17.P>
95. McNealy, Roderick M. (1994). *Making Customer Satisfaction Happen; A Strategy for delighting customers*. Chapman and Hall.
96. *Mil Med* 2002, 167(10):842-5. PubMed Abstract
97. MOH. (2008). *National Strategic Plan 2008-2010,* Palestine, 6-38
98. Murray, J. Dennis and Peter A. Keller.(1991). *Innovations in Rural Community Mental Health*,Mansfield, Pennsylvania: Mansfield University Rural Services Institute. Vol 46(3), Mar 1991, 220-231
99. Nelson E., Larson C.(1993). *Patients good and bad surprises: How do they relate to over all patient satisfaction;* Quality Review Bulletin, 3: 89-94.
100. Newsome, P. R.H., Wright G.H. (1999). *A review of Patient*

Satisfaction: Concepts of Satisfaction; British Dental Journal, 186: 161-165.

101. Oliver R. (1993). *Cognitive, affective and attribute bases of the satisfaction response:* Journal of consumer response, 20: 418-430.

102. O'Malley, M, Fletcher, S, Fletcher, R, & Earp, J:Measuring patient waiting time in a practice setting: a comparison of methods. J of Amb Care Manage 1993;6:20-27.

103. Oliver, R. (1981), "Measurement and Evaluation of Satisfaction Processes in Retail Settings," Journal of Retailing, 57 (Fall): 25-48

104. Owuor-omondi, L,Altholang ,D. ,and Diseko,R.1986. The change role of family welfare educators? An evaluation of the role of the FWES in the implementation of primary health care in Botswana.

105. Owuor-omondi, L,Altholang ,D. ,and Diseko,R.1987. Village health committees viable instrument for community mobilization for primary health care in Botswana

106. Palestinian Central Bureau of Statistics. (PCBS). (2005). Demographic Statistics Revised Estimates.

107. Palestinian National Authority. *Ministry Of Health, Annual Report 2006*. (2007, Palestine

108. Parasuraman A., Berry L. (1988). *SERVQUAL : A multiple item scale for measuring consumer perceptions of service quality,* Journal of Retail, Vol.1, PP. 12-40

109. *Patrick DL, Scriven E, Charlton JRH. Disability and patient satisfaction with medical care. Med Care 1983; 21: 1062–1075.*

110. Pelz S. L , Struening E (1985) The multidimensionality of patient satisfaction with a clinic visit . JCommunity Health 10 : 42 ± 553

111. Penchansky R, Thomas JW.(1981). The *concept of access: definition and relationship to consumer satisfaction.* Med Care. 1981 Feb;19(2):127-4

112. Penchansky, R. and W. Thomas. (1981). *"The Concept of Access: Definition and Relationship to Consumer Satisfaction,*" Medical Care, :127-140.

113. Peterson R. (1992). *Measuring Customer Satisfaction: Fact and artifact*: Journal of Academic Market Science, 20: 61-71.

114. Pia Markkanen ,ScD ,Margaret ScD ,CID ,Cathrerine Galligan ,Anila Bello ,ScD . 2007 cleaning health care facilities .Reducing

human health effects and environmental impact .

115. Pope C, Mays N. Opening the black box: an encounter in the corridors of health services

116. Press, I., Ganey, R.F., Malone, M.P, "Satisfied patients can spell financial well-being," Healthcare financial management, (1991); 45, 2, pp.34-42.

117. Prochaska J.O. 1994 Strong and Weak Principles for Progressing from Precontemplation to Action of the Basis of Twelve Problem Behaviors. Health Psychology.12(1):47–51.[PubMed].

118. Prochaska J.O., DiClemente C.C. Transtheoretical Therapy: Towards a More Integrative Model of Change. Psychotherapy: Theory, Research and Practice. 1982;19(3):276–88.

119. *Quality*, Thousand Oaks, C.A., SAGF, 1194.

120. Quick, Sam, Flashman R and Gibeaux A.(1981). *SOS Learning Networks: A Model of Interorganizational Cooperation*. University of Kentucky. Nonprofit and Voluntary Sector Quarterly. 10: 67-77

121. Rankin D,. Cooke D. D., Clark. M., Heller S., Elliott J. and Lawton J. (2011). "How and why do patients with Type 1 diabetes sustain their use of flexible intensive insulin therapy? A qualitative longitudinal investigation of patients' self-management practices following attendance at a Dose Adjustment for Normal Eating (DAFNE) course" for the UK NIHRDAFNE Study Group Diabet. Med. 28, 532–538.

122. Research. British Journal Medical, 1993;306:315-318.

123. Reti, S. (1994). Patient waiting times. New Zealand Med J;107:104-6.

124. Rob Dinger. (2000). *A guide to Integrated Participatory Rural Accessibility Planning.* ILO/ASIST

125. Ross, C., G. Frommelt, L. Hazelwood and R. Chang. (1987). *"The Role of Expectations in Patient Satisfaction with Medical Care,"* Journal of Health Care Marketing,: 16-26.

126. Rubin HR, Ware JE, Hays RD. (1990). *The Patient Judgments of Hospital Quality (PJHQ) questionnaire*. Medical Care; 28: S22–S29.

127. Rust, T.; Oliver L.(1994). *Service Quality: Insights and Managerial Implications from the Frontier. In Service Quality: New Directions in*

Theory and Practice, edited by R. T. Rust and R. L. Oliver, pp. 1-19. Thousand Oaks, CA: Sage

128. Scammon, D. and L. Kennard. (1983*). "Improving Health Care Strategy Planning Though Assessment of Perceptions of Consumers, Providers and Administrators*," Journal, of Health Care Marketing,: 9-17.

129. Scott T. Learner. (1986). *The Changing Relationship between Doctor and Patient: Some personal observations;* Mid-west Research Institute.

130. Segall A., Burnett M. (1980). *Patient Evaluation of Physician role performance;* Social Science and Medicine.14, 269-278.

131. Shaheen M. (2005). *Review of Community Mobilization Experiences in Palestine*. Hanan Project. West Bank/Gaza.

132. Shaikh B, et al. (2008). *Using Servqual for Assessing and Improving Patient Satisfaction at a Rural Health Facility in Pakistan,* Pakistan

133. Sheldon T. (2005). *The healthcare quality measurement industry: time to slow the juggernaut?* Quality and Safety in Health Care.; 14(1):3-4.

134. Shikiar R, Rentz AM. (1993). *Satisfaction with medication. An overview of conceptual, methodological, and regulatory issues*. Value Health 2004; 7:204–15Medical Care; 31: 834–845.

135. Shortell S.M. (1976). *Continuity of medical care: conceptualization and measurement.* Medical Care; 14 (5), 377 Ð 391.

136. Sitzia J, Wood N. (1997*). Patient satisfaction: a review of issues and concepts. Soc Sci Med; 45: 1829–1843.*

137. Szarsz , T.S., Hollender, M.H. (1956*). A contribution to the philosophy of medicine: The basic models of the Doctor-patient relationship;* Archives of Internal Medicine, 97: 585-592.

138. Taylor, C. and Benger, J.R. (2004). *Patient satisfaction in emergency medicine.* Emergency Medicine Journal 21: 528–32

139. Tham, K.Y., Richmond, P.W. and Evans, R.J. (1995). *Senior house officers' work activities in an accident and emergency department.* Journal of Accident and Emergency Medicine 12(4): 266–9

140. Than Sien. (2001). *Health Sector Reform: Issues and Opportunities; Regional Health* The community

141. The Health Communication Unit (THCU). (2003). http://www.thcu.ca. *Health Communication and Community Mobilization: Complementary*

Strategies for Health Promotion. Version 1.1. The Health Communication Unit, at the Centre for Health Promotion, University of Toronto. Canada.

142. Thomas, John, Thomas E. Hart and Stuart C. Smith. (1989). *Building Coalitions, ERIC Clearinghouse on Educational Management,* Eugene, Oregon, Office of Educational Research and Improvement (ED), Washington, D.C. USA.

143. Tool Box *http: //ctb.ku.edu*. (Accessed online on at 8 May 2011).

144. Tucker, F. and J. Tucker (1985), "An Evaluation of Patient Satisfaction and Level of Physician Training," Journal of Health Care Marketing, 5 (Summer): 31-38.

145. Tzeng, Huey-Ming, Ketefian S.(2002). *The Relationship between Nurses' Job Satisfaction and Inpatient Satisfaction: An Exploratory Study in a Taiwan Teaching Hospital;* Journal of Nursing Care Quality, Article 4, 16(2): 39- 49.

146. UNFPA. (2004). *Situational Analysis for UNFPA Country Program Development, Occupied Palestinian Territory*, Palestine. 2-33

147. UNICEF (2004) Far more pregnant women getting antenatal care March 2004 , http / unicef . org

148. UNRWA CM. *plan and activities*. (FIP , 2010)

149. UPMRC. (2007). *Series of Reports*,

150. Vision 2020. (2000*). A Hand Book of Development Philosophy for Bhutan.*

151. Vuor,H., and hastings ,J.E.F ,(Eds) 1986, Patterns of community participate in primary health care

152. W.H.O. report 2000,5-44, 2002, p 4 2007 .

153. Wallersein N.(,2006). WHO–University of new Mexico-*the evidence on effectiveness of empowerment to improve health* –health evidence net work.

154. Ware JE, Davies-Avery A., Stewart A. (1978). The measurement and meaning of patient satisfaction with medical care, Health and Medical Care Services Review.; 1:1-15.

155. Ware JE, Snyder MK, Wright WR, Davies AR. (1983).*Defining and measuring patient satisfaction with medical care.* Evaluation and Program Planning; 6: 247–263.

156. Warren J. Ferguson, Lucy M. Candib. (2002). *Culture, Language, and Doctor Patient Relationship*, Fam Med, 34(5): 353-61.

157. Wesatway M. S., Rheeder P., Van Zyl D.G., Seager J. R. (2003). *Interpersonal and organizational dimensions of patient satisfaction: the moderating effects of health status*. *Int J Qual Health Care (2003) 15 (4): 337-344.*

158. Westin, A. F. (1967). *Privacy and Freedom*, Atheneum: New York.

159. Westin, A. F. (2003*). Social and political dimensions of privacy. Journal of SocialIssues, 59*(2), 431-453

160. White and Barbara, L. (1997). *Mobilizing the Public to Better Serve Children At-Risk*. Community Relations and Public Information. Jackson, Mississippi: Jackson Public Schools.

161. WHO (World Health Organization). (2000). *World Health Report 2000.* Geneva: WHO *Draft Report of Technical Consultation of Effective Coverage in Health Systems* (27–29 August 2001, Rio De Janeiro, Brazil). Geneva: WHO. <http://www.who.int/health- systems-performance/technical consultations/effcov_report.pdf>

162. WHO, SEARO, (2010). New Delhi. *South-East Asia regional conference on epidemiology*, New Delhi, The proceedings. India.

163. Williams S, Weinman J, Dale J, Newman S. *Patient expectations: what do primary care patients want from the GP and how far does meeting expectations affect patient satisfaction.* Family Practice, 1995; 12(2): 193-201.

164. Williams SJ, Calnan M.(*1991*). *Convergence and divergence: assessing criteria of consumer satisfaction across general practice, dental, and hospital care settings. Soc Sci Med; 33: 707–716.*

165. *Williams S, Calnan M. Key determinants of consumer satisfaction with general practice. Fam Pract 1991; 8: 237–242.*

166. Wilson P., Mc Namara J. (1982). *How perceptions of a simulated physician-patient Interaction influence intended satisfaction and compliance;* Social Science and Medicine, 16: 1699-1704.

167. Wright S. (1985). Health satisfaction: *A detailed test of the multiple discrepancies*. Social Indicators Research; 17: 299-313.

168. Xu, K T. (2011), *"The Combined Effects of Participatory Styles of Elderly Patients and Their Physicians on Satisfaction"*. Health Services Research 39:2 (April 2004), pp. 337-392.

169. Young-Mohon,P.,(1996). *An analysis of concept patient satisfaction as it relates to contemporary nursing*,journal of advanced nursing 24:1241-1248

170. Zapka JG, Palmer RH, Hargraves JL, Nerenz D, Frazier HS, WarnCK. (1995). *Relationships of patient satisfaction with experience of system performance and health status.* Ambulatory Care Management; 18:73-83.

171. Zoller JS, Lackland DT, Silverstein MD: *Predicting patient intent to return from patient satisfaction scores*. *J Ambul Care Manage* 2001, 24(1):44-50.

Annexes:

Annex (1): Arabic Version of the Consent Form:

"استبانة "

أختي الكريمة / أخي الكريم

يقوم الباحث بإجراء دراسة بعنوان "دراسة أولية حول اثر استراتيجيات التعبئة المجتمعية على رضا مرضى السكري عن الخدمات الصحية الحكومية المقدمة لهم في منطقة نابلس" وذلك استكمالا لمتطلبات الحصول على درجة الماجستير في السياسات والإدارة الصحية.

لهذا تم تصميم هذه الاستبانة بهدف الإطلاع على احتياجاتكم الصحية. إننا نقدر ونثمن وقتكم ومشاركتكم، فإننا نستأذنكم بتخصيص عشرة دقائق تقريبا لتعبئة هذا الاستبيان الذي يتمتع بكامل السرية ولكم كامل الحرية في المشاركة أو عدمها، لذا نرجو من حضرتكم التكرم بتعبئة هذه الاستبانة بعد قراءة كل عبارة من عبارات الاستبانة قراءة متأنية لما له من أثر كبير في الحصول على نتائج دقيقة، ووضع علامة (X) في الخانة التي تعبر عن مدى موافقتكم عليها علما بأن المعلومات المقدمة لن تستخدم إلا لأغراض البحث العلمي فقط .

إن مشاركتكم في هذه الدراسة هي طوعية ونؤكد لكم بأن المعلومات ستعامل بسرية تامة، وعليه لا داعي لكتابة الاسم أو أية معلومات تدل على شخصكم الكريم وسيزودكم الباحث بالنتائج التي تتوصل إليها الدراسة إن رغبتم في ذلك.

إذا كانت لديكم أية تساؤلات، الرجاء عدم التردد في الاتصال بنا.

شاكرين لكم حسن تعاونكم. وتقبلوا فائق الاحترام .

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Annex (2): Arabic Version of the Questionnaire:

الجزء الأول

1-اسم المركز : .....

2- مقدم الخدمة :☐ - قطاع حكومي □- قطاع خاص □- وكالة □- مراكز خيرية □- غير ذلك

3-العمر :□ 20-29 □ 30-39 □ 40-49 □ 50-59 □ 60-69 □ غير ذلك

4- الجنس : □- ذكر □- أنثى-

5- الحالة الاجتماعية ☐- متزوج /متزوجة ☐- أعزب/عزباء ☐- مطلق/مطلقة ☐- أرمل/أرملة

6- المستوى التعليمي ☐- أمي ☐- ابتدائي ☐- إعدادي ☐- ثانوي ☐- دبلوم ☐- جامعي

7- الدخل الشهري: ☐ 200 دينار ☐ 201-400 دينار ☐ 401-600 دينار ☐ 601 فأعلى

8- الوضع الاقتصادي:☐ سيء ☐ متوسط ☐جيد ☐ممتاز

9- هذه الزيارة ☐- الأولى ☐- الثانية ☐- الثالثة ☐- أكثر من ذلك-

10- هل اخترت المركز ☐- لقرب المركز ☐- بسب وجود خدمات خاصة بالمركز ☐- سمعة المركز ☐- وجود أخصائي بالمركز ☐- سبب أخر

11- علمت عن المركز من ☐- صديق \صديقه ☐- جار\جاره ☐- الراديو ☐- المجلس المحلي ☐- الجريدة ☐- غير ذلك

12- ما نوع التامين الذي تمتلكه : ☐- تامين حكومي ☐ - تامين خاص ☐- لا املك

13- تاريخ عائلي لمرض السكري ☐- ايجابي ☐- سلبي

14- أي الأمراض تعاني منها ☐-ضغط ☐-القلب والشرايين ☐- كلى ☐-أمراض أخرى

15- منذ متى وأنت مريض ☐ اقل من 6 شهور ☐ أكثر من 6شهور -1 سنة ☐-أكثر من ذلك

16-متى بدأت العلاج ☐- بعد اكتشاف المرض مباشرة ☐- في وقت متأخر

الرقم	المحور	موافق بشدة 5	موافق 4	محايد 3	غير موافق 2	غير موافق بشدة 1
جودة الخدمة (Quality of services)						
1	الخدمات إجمالا كانت ممتازة كما كان متوقعا أصلا					
2	إن ألمشكله الصحيةالتي التجأت من اجلها قد عولجت					
3	حصلت على العلاج (الوصفة الطبية) لهذه المشكلة					
4	كان واضحا اهتمام الطبيب(مقدم الخدمة) الكبير بمشكلتك الصحية					
5	شعرت بأنك مرحب بك من الموظفين بشكل عام					
6	شعرت باهتمام الموظفين طوال مراحل الخدمة في العيادة					
7	موظفو المركز كانوا يقدمون العون كلما اقتضى ذلك					
8	أنت تثق بهذا المركز لان سمعته جيده بتقديم الخدمات الصحية					
9	أنت تشعر بالراحة لان الأطباء والعاملين مؤهلون ولديهم خبره في تقديم هذه الخدمة					
10	شعرت بان الموظفين كانوا لطيفين معك					
11	التعليمات الطبية عن الوصفة سهلة الفهم					
12	هل تم فحص السكري قبل الدخول للطبيب؟					
13	هل الخدمات التي أتيت من اجلها موجودة ضمن نفس المركز					
النظافة (Cleanliness)						
14	مكتب الطبيب كان نظيفا					
15	محيط المركز الصحي الخارجي نظيف					
16	منطقة الانتظار الخاصة بالمراجعين نظيفة					
17	العاملون الصحيون يستخدمون أدوات مخصصة نظيفة					
18	شراشف السرير كانت نظيفة					
وقت الانتظار (Waiting time)						
19	إن الموظفين حافظوا على أن يكون وقت الانتظار مناسبا في المركز					
20	إجراءات التسجيل كانت سريعة					
21	الموعد لأخذ الخدمة كان مناسبا					
22	الانتظار قبل الدخول لغرفة الفحص كان مناسبا لك					
23	الوقت الذي قضيته مع مقدم الخدمة كان مناسبا لك					
24	إجمالي الوقت المستغرق لأخذ الخدمة جميعها كان مناسبا لك					
الخدمات المقدمة (Services delivered)						
25	هل يعمل لكم فحص سكري قبل كل زيارة ؟					
26	هل يعمل لكم فحص شامل (السكري التراكمي/ الكولسترول/ الدهنيات)					
27	هل تتوفر الأدوية الأنسولين في المركز دائما ؟					
28	هل يعمل لكم فحص الضغط والوزن قبل كل زيارة ؟					
29	هل يتم تحويلكم للمشفى عند الحاجة بسهولة					
30	هل يتم تزويدكم بنشرات طبية عن مرض السكري داخل المركز ؟					
31	هل يعمل لكم فحص للقدمين بشكل دوري ؟					

32	هل يتم عرضك على طبيب أخصائي (قلب،كلى،غدد صماء) ؟					
33	هل يتم عمل تخطيط قلب بشكل دوري ؟					
الخصوصية (Privacy)						
34	كان اهتمام العاملين بخصوصيتك أثناء الفحص ملحوظا					
35	غرفة الفحص مجهزة بوسائل الحفاظ على الخصوصية					
36	الموظف أغلق باب الغرفة حفاظا على خصوصيتك					
37	الطاقم يحافظ على سرية المعلومات بشكل عام					
الوصول للمركز (Accessibility)						
38	الوصول للمركز كان سهلا					
39	المواصلات كانت متوفرة					
40	المركز ضمن مسافة معقولة					
41	الوقت المطلوب أثناء الذهاب والإياب للمركز كان معقولا					
42	كانت تكلفة الوصول للمركز المادية معقولة					
43	قدومك للمركز كان أمنا					
44	وجود موقف للسيارات تابع للمركز يشجعك للحضور إليه لأخذ الخدمة					
45	سهولة الوصول إلى الطاقم الطبي عند حدوث مشكلة					
46	سهولة الوصول إلى الطبيب الأخصائي عند الحاجة					
التواصل والتعلم (Learning & communication)						
47	هل تلقيت تثقيفا صحيا خارج المركز؟					
48	هل تلقيت تثقيفا صحيا داخل المركز(نشرات طبية- ندوات)					
49	هل قام الطاقم الطبي بتعريفك بمرضك وطرق الحماية منه؟					
50	مستوى التواصل بين المريض والأطباء جيد					
51	مستوى التواصل بين المريض وطاقم التمريض جيد					
52	طاقم التمريض يستمع إلى شكوى المريض					
53	طاقم التمريض والأطباء يجيبون على أسئلة المريض					
54	طاقم التمريض يبذل جهدا لجعل فترة وجود المريض في العيادة مريحا					
55	العلاقة بين المريض وأفراد الطاقم الطبي تمتاز بالإخوة والصداقة					
56	الطبيب يستخدم في حديثه مع المريض بعض المصطلحات الطبية دون توضيح لمعناها					
57	الطاقم الطبي يعطي المريض مقدارا من الاحترام في التعامل					
58	مقدار ثقة المريض بالطاقم الطبي الذي يتولى علاجه جيدة					
59	الطبيب يعطي المريض وقتا كافيا في فحصه وإعطائه التعليمات الطبية					
60	موظف الاستقبال يوضح الأمور بهدوء					
معدل مشاركة المجتمع (Community participation rate)						
61	هل جرى إشراكك في التخطيط للبرنامج المطروح في العيادة منذ بداية المشروع					
62	هل بدا إشراكك في التخطيط في منتصف المشروع؟					
63	هل أجريت عملية تقييم للبرنامج قبل البداية؟					

64	هل جرى نقاش موسع لوضع أولويات أثناء مرحلة التقييم ؟					
65	هل جرى إشراكك في مراقبة وتقييم البرنامج؟					
66	هل مشاركتك في البرنامج ساهمت بتعريفك بشكل صحيح بمرضك والوقاية منه ؟					
67	هل مشاركتك في اللجان المجتمعية ساهمت برفع الوعي لديك ولدى المرضى الآخرين ؟					
68	هل شعرت بتغير بطبيعة الخدمات ألمقدمه نحو الأفضل في العيادة بعد تطبيق التعبئة المجتمعية؟					
69	هل شعرت بتغير في ألمعاملة نحو الأفضل من قبل الطاقم الطبي بعد مشاركتك في هذه اللجان؟					

Annex (3): English Version of the Consent Form:

Dear Colleagues,

The researcher is doing a study entitled "To Explore the Effect of Community Mobilization Strategies on Client Satisfaction with Governmental Health Services Provided to Diabetic Patients in Nablus Villages" with the objective to have the Master degree in Health Management and Policies. A questionnaire was determined to update your needs. I am highly appreciated with your cooperation if you could take the time to go through this questionnaire and answer the relevant questions. Hopefully, it will not take you longer than 10 minutes to fill in this questionnaire post careful reading each single statement because of its high impact to attain accurate results, so, please be completely honest in your assessments and answer the questions as fully as possible. For every item, please place an 'X' in the scoring box that most closely matches your conformity noting that the introduced information will not be used but for scientific research only.

Your participation in this study is optional, I can assure you that this information will be treated confidentially, hence, you are not being asked to write your name or any information leads to your noble personality. The researcher will offer you the results if you would like to. If you have any other queries, please do not hesitate to contact me.

Thank you for your time and consideration.

Researcher: Osama Ayesh

Mobile: 0599940155

Mail: osama_ayesh@yahoo.com

Annex (4): English Version of the Questionnaire:

No:	Statement	Strongly Agree 5	Agree 4	Neutral 3	Disagree 2	Strongly Disagree 1
Quality of services:						
1	Overall services were perfect as originally expected.					
2	Health problem you came for is treated or within treatment.					
3	You had the treatment / prescription.					
4	It was clear that doctor was very interested in your health problem.					
5	You felt you were welcomed generally by staff.					
6	You felt you were interested by staff all stages of being serviced in the clinic.					
7	Staff provided assistance whenever possible.					
8	You trust this center because it has a good reputation through providing health services.					
9	You feel comfort because the doctors and health workers are qualified and have experience in providing this service.					
10	You felt that staff was kind with you.					
11	Medical instructions about the prescription were understandable.					
12	You were tested for diabetes before seeing the physician.					
13	Health services you came for are presented within the center					
Cleanliness:						
14	Physician's office was clean.					
15	Circumscription of center was clear.					
16	Waiting area for the reviewers was clean.					
17	Health workers use specific clean tools.					
18	Bed sheets were clean.					
Waiting time:						
19	Staff kept the waiting time to be fit.					
20	Registration producers were fast.					
21	The engagement to take the service was timely.					
22	Waiting before entering the test room was appropriate.					
23	The time you spent with the service provider was convenient.					
24	Gross time deposited to take the whole service was fit.					
Services delivered:						
25	You are tested for diabetes before each visit					
26	Comprehensive test (Cumulative diabetes, Cholesterol, fat) is carried out each six month					
27	Insulin medicine and tablets are permanently available in the center					
28	You are tested for weight and blood pressure each visit					
29	When needed, you are transferred to hospital easily					
30	You are being provided with medical					

	literatures about diabetes in the center					
31	You are being checked for feet regularly					
32	You are submitted to a specialist doctor (heart, kidney, endocrine glands)					
33	ECG is done periodically					
Privacy:						
34	It was notable taking care of your privacy during the test.					
35	The testing room was equipped with privacy means.					
36	To protect your privacy, the health worker closed the door.					
37	Generally, the team maintains the information secrecy.					
Accessibility:						
38	Accessibility to the centre was easy.					
39	Transportations were available.					
40	The center is located within reasonable range.					
41	Home and away to the center due to the adequate time was reasonable.					
42	Cost accessibility was acceptable					
43	It was safe to come to the center.					
44	The existence of a parking encourages you to attend the center to take the service.					
45	When a problem happens, it is easy for the staff arrivals.					
46	When in need, it is easy for the specialist arrivals.					
Learning & Communication:						
47	Did you have a health education outside the center					
48	Did you have a health education inside the center (medical literature, seminars...)?					
49	Were you identified to your illness and means of protection by the staff?					
50	Communication level between the patient and physician was good.					
51	Communication level between patient and the staff was good.					
52	Complaint of patient is being heard by the staff.					
53	Staff and physicians answer all questions.					
54	Staff are doing their best in order the patient feels comfort.					
55	Patient-staff relationship is characterized by brotherhood and friendship.					
56	Physician uses some medical terms during his speech to the patient without elaboration.					
57	Patient is being respected by staff					
58	Patients' trust in staff is good.					
59	Physician gives enough time in testing and instructing the patient.					
60	Receptionist explains issues quietly.					
Community participation rate:						
61	Did you participate in planning the posed programme since the project has begun?					
62	Did you participate in the middle of the project?					
63	Did you make an evaluation process to the programme before it has begun?					
64	Is an extensive discussion taken place to set					

	priorities during evaluation process?					
65	Have you been signed up to monitor and evaluate the programme?					
66	Did your participation in the programme contribute correctly the introduction of your illness and its preservation?					
67	Did your participation in community committees contribute in raising awareness to you and other patients?					
68	Did you feel the change in the nature of services provided for the better in the clinic after the application of CM?					
69	Did you feel a change in the treatment for the better by the medical staff after your participation in these committees?					

Annex (5): List of Persons Shared the Questionnaire Preparation and Critique:

Name	Title	Location
Dr. Mohammed Shahin	Supervisor/ Lecturer	Al-Quds University
Dr. As'ad Ramlawi	PHC Director	Ministry of Health
Dr. Abdel Mohsen	Lecturer	Al-Quds University
Dr. Abdel Karim	Lecturer	An-Najah University
Mr. Hatem Sawalmeh	Statistician	Arab American University
Mrs. Randah Bani O'deh	Health Management	Flagship Project

Annex (6): Collage letter to the Primary Health Care Director:

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

التاريخ: 2010/11/27
الرقم: ك ص ع/407/2010

حضرة الدكتور اسعد رملاوي المحترم
مدير عام الرعاية الأولية/ وزارة الصحة الفلسطينية

الموضوع: مساعدة الطالب أسامة عايش

تحية طيبة وبعد،،
يقوم الطالب أسامة مصطفى عبد الحميد عايش برنامج ماجستير السياسات والإدارة الصحية/ جامعة القدس بإجراء بحث بعنوان:
"To explore the effect of community mobilization strategies on client satisfaction with Governmental Health services provided to diabetic and hypertensive patients".

كمتطلب لبحث رسالة الماجستير. أرجو من حضرتكم التكرم وتسهيل مهمة الطالب بتوزيع استبيان على مرضى عيادات الرعاية الأولية منطقة نابلس. علماً بان هذه المعلومات خاصة للبحث العلمي فقط.

وتقبلوا مع فائق الاحترام،،

د. أسمى الإمام
عميدة كلية الصحة العامة

نسخة: الملف

Jerusalem Branch/Telefax 02-2799234
Gaza Branch/Telefax 08-2878166,2878177
P.O. box 51000 Jerusalem

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فرع غزة / تلفاكس 08-2878166-2878177
ص.ب. 51000 القدس

a

Annex (7): Collage letter to the Flagship Director:

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

التاريخ: 2010/11/27
الرقم: ك ص ع/ 106/2010

حضرة السادة إدارة مؤسسة (Flagship) المحترمين

الموضوع: مساعدة الطالب أسامة عايش

تحية طيبة وبعد،،

يقوم الطالب أسامة مصطفى عبد الحميد عايش برنامج ماجستير السياسات والإدارة الصحية/ جامعة القدس بإجراء بحث بعنوان:

"To explore the effect of community mobilization strategies on client satisfaction with Governmental Health services provided to diabetic and hypertensive patients".

كمتطلب لبحث رسالة الماجستير. أرجو من حضرتكم التكرم وتسهيل مهمة الطالب بعمل مقابلات مع طواقم المؤسسة وجمع معلومات عن إدارة المؤسسة. علماً بان هذه المعلومات خاصة للبحث العلمي فقط.

وتقبلوا مع فائق الاحترام،،

د. أسمى الإمام
عميدة كلية الصحة العامة

نسخة: الملف

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